

1

M
X
I
0
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL HOME DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2680

CERTIFICATE OF DEATH

Reg. Dist. No.

02661

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. LENGTH OF STAY IN 1b <u>35yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pleasant Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>J. Allison</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Franklin D. Allison</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Henry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Louis F. Sisson</u>		18. ADDRESS <u>1603 Providence Road Baltimore 4, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u> </u> Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-19-54</u> , 19 <u> </u> , to <u>3-31-</u> <u>61</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>61</u> , and that death occurred at <u>11A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin E. Strobel</u>		DATE SIGNED <u>3-31-61</u>	
PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		<u>Reisterstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>York Christian Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>York, Balto Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		24a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>	
ADDRESS <u>5305 Harford Road #14</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Turner</u>	

360

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **02662**

2681

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines				d. STREET ADDRESS 1909 Forest Park Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOSEPH MERRYMAN ANDERSON, Sr.				4. DATE OF DEATH Month March Day 23 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1879		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales		10b. KIND OF BUSINESS OR INDUSTRY Produce		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Horace A. Anderson				14. MOTHER'S MAIDEN NAME Mary XXXXX Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-32-4416		INFORMANT Address Daisy E. Anderson-1909 Forest Park Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Mar. 7, 1961	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 17, 1949</u> to <u>March 23, 1961</u> , that I last saw the deceased alive on <u>March 22, 1961</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE Abraham B. Hurwitz		ADDRESS (Street, city or town, state) DATE SIGNED M.D. 3403 Garrison Blvd. Balto, 15, Md 3/23/61					
PHYSICIAN'S NAME (Type) Abraham B. Hurwitz, M.D.		3403 Garrison Boulevard					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/1961		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS Ellsworth Armacost-4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR DATE MAR 27 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA

1900

San Francisco

California

James M. Jones

1900 Forest Park Avenue

JOSEPH ALBERTSON, JR.

1900 Forest Park Avenue

San Francisco, California

James A. Anderson

1900 Forest Park Avenue

San Francisco, California

James A. Anderson

1900 Forest Park Avenue

San Francisco, California

James A. Anderson

1900 Forest Park Avenue

San Francisco, California

James A. Anderson

1900 Forest Park Avenue

San Francisco, California

James A. Anderson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2682

02663

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b 2 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5522 Selma Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nina Middle M. Last Appy		4. DATE OF DEATH Month March Day 29 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1914
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Marie Grimes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-30-4134	
17. INFORMANT Jesse M. Appy		Address 5522 Selma Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Cervix DUE TO with Metastases to spine Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) 171X (c) 6 mo.		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1960 to Mar 29, 1961 , that (I) (we) last saw the deceased alive on Mar 29, 1961 , and that death occurred at 2:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE A. Bradley Daugharthy		22b. DATE SIGNED 3-30-61	
22c. PHYSICIAN'S NAME (Type) A. Bradley Daugharthy		22d. ADDRESS 1264 Francis Ave., Balto. 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/1/61	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Dorsey, Howard, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Spring Rd.		25a. REC'D BY REGISTRAR DATE APR 3 '61	
25b. REGISTRAR'S SIGNATURE Walter L. France			

0383

0383

0383

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

Address

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2683

02664

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OWINGS Mills</u> c. LENGTH OF STAY IN 1b <u>22 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rosewood State Training School</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>100 So. Carlton</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>CHARLES SHERIDAN ARMSTRONG</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>20</u> Year <u>1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>FEB 12, 1956</u>		9. AGE (In years last birthday) <u>5</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Eugene Armstrong</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Louise Tasker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Chart of Rosewood Owings Mills, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of food</u> 753.1 DUE TO (b) <u>General debility-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Severe microcephaly</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Mental retardation</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 26, 1961</u> to <u>Mar 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 20, 1961</u> , and that death occurred <u>3:45 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Olive Reid Harris</u> M.D.				22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <u>Olive Reid Harris</u>				22d. ADDRESS <u>Owings Mills, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Mar 23 - 41 Embury Road</u>				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Hume</u>				25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
 15M 9/60

20650

132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
B
M
2684
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02665

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE		c. LENGTH OF STAY IN 1b 9 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME		d. STREET ADDRESS 2003 RAMSEY ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle M Last ARNOLD		4. DATE OF DEATH Month MAR Day 9 Year 19 61	
5. SEX FE	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-9-1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOHN GATER MAN		14. MOTHER'S MAIDEN NAME ELIZABETH OLD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-03-0008	
17. INFORMANT Frank L. Smith Jr. Address Cockeysville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Cardio Vascular Accident (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-18 , 19 52 , to 3-9 , 19 61 , that (I) (we) last saw the deceased alive on 3-9 , 19 61 , and that death occurred at 7:30 P , from the causes and on the date stated above.			
22a. SIGNATURE Walter T. Kees M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 3/9/61	
22c. PHYSICIAN'S NAME (Type) WALTER T. KEES		22d. ADDRESS COCKEYSVILLE, MD	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE THEREOF 3-13-61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street		ADDRESS 25a. REC'D BY REGISTRAR DATE MAR 13 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

0300

0300

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Certificate	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death of the deceased. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
2685
02666

1. NAME OF DECEASED (Type or Print) VERA BADINGER		2. DATE OF DEATH March 12 1961				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 5 Island Pt Road, Baltimore 24 (If NOT in hospital or institution, give STREET ADDRESS OR LOCATION) Baltimore County Highlandtown.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore 24 (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 5 Island Point Road				
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH DEC 6 1960	9. AGE (In years last birthday) 3	10. If Under 1 Yr. Months Days 3 7	11. If Under 24 Hrs. Hours Min. 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland (City)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ROBERT Badinger		14. MOTHER'S MAIDEN NAME EMILY CURRY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Parents		18. ADDRESS Same		

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 751X Hydrocephalus	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
	(A) DUE TO			
	(B) DUE TO			
	(C) DUE TO			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Meningoencephalitis				
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION March 12 1961	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hydrocephalus	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

22. I certify that (I) (this hospital) attended the deceased from Birth to Dec 19 61 that (I) (we) last saw the deceased alive on March 7 19 61 and that in (my) (our) opinion death occurred at 5:30 a.m. from the causes and on the date stated above.				
23a. SIGNATURE Andrew B. Richards ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.	23b. ADDRESS Johns Hopkins Hospital	23c. DATE SIGNED March 13		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Mar 15 - 61	24c. NAME OF CEMETERY OR CREMATORY St. Carmel Cemetery	24d. LOCATION (City, town, or county) (State) Balto Md	
25a. DATE REC'D BY HEALTH DEPT. MAR 16 1961		25b. NAME OF REGISTRAR Robert H. Adams		25c. FUNERAL DIRECTOR Joseph M. Connolly

00000

00000

STATE

STATE

CHARTER

STATE OF TEXAS

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

CHARTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18

VR A15 (4)
15M 9/60

1

2686

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02667

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SHADY NOOK NURSING HOME</u>				d. STREET ADDRESS <u>11500 Frederick Rd</u>			
3. NAME OF DECEASED (Type or print) <u>RICHARD PRICE</u> Middle				Last <u>BAER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 26, 1871</u>	
9. Age in years (last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LUMBER MFG.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>ARTHUR P. BAER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH ANN PRICE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>William Vogdes</u>				Address <u>1001 W. Calvert St. Balt. 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Chronic myeloid leukemia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1961</u> to <u>March 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 21, 1961</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-23-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>				22d. ADDRESS <u>1118 Paul St. Balt. 2. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MARCH, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McDonald & Son Co</u>				ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 27 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

0000

0000

M

I

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2687

02668

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Woodstock				c. LENGTH OF STAY IN 1b Woodstock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hernwood Road				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mr. Nickolas Baker				4. DATE OF DEATH Month Day Year March 8, 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sep't. 1, 1862	9. AGE (In years lost birthday) 98 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown Edith Cannon Maddaway			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Edith G. Baker, Hernwood Rd. Woodstock, P.O.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Hypertensive C.V. disease - renal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Insufficiency & peripheral edema (c) 10 years						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 2 1960 to MAR 8 1961 , that (I) (we) last saw the deceased alive on MAR 8 1961 and that death occurred at 12 noon from the causes and on the date stated above.							
22a. SIGNATURE Thomas E. Wheeler				22b. DATE SIGNED 12 MAR 1961		22c. PHYSICIAN'S NAME (Type) Dr. Thomas Wheeler	
22d. ADDRESS 3601 Clifmar Rd. Balto. 7, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town, or county) (State) Randallstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Byers				25a. REC'D BY REGISTRAR MAR 13 '61		25b. REGISTRAR'S SIGNATURE Carlton L. Kraus	

BP

MEMORANDUM FOR THE CHIEF OF STAFF

1967

050000



1. The purpose of this memorandum is to provide information regarding the proposed changes in the structure of the Office of the Chief of Staff, Department of the Army, for the year 1967.

2. The proposed changes are based on the recommendations of the Joint Chiefs of Staff and the Department of Defense, and are designed to improve the efficiency and effectiveness of the Office of the Chief of Staff.

3. The proposed changes include the following:

- a. The creation of a new position of Deputy Chief of Staff, to be held by a General.
- b. The reorganization of the staff sections to reflect the current and future needs of the Department of the Army.
- c. The elimination of certain positions that are no longer necessary or are redundant.

4. It is recommended that the proposed changes be implemented as soon as possible, and that the necessary steps be taken to ensure a smooth transition.

5. The proposed changes will be implemented in accordance with the provisions of the Department of the Army Regulation 600-10, and will be subject to the approval of the Secretary of Defense.

6. The proposed changes will be implemented in accordance with the provisions of the Department of the Army Regulation 600-10, and will be subject to the approval of the Secretary of Defense.

7. The proposed changes will be implemented in accordance with the provisions of the Department of the Army Regulation 600-10, and will be subject to the approval of the Secretary of Defense.

8. The proposed changes will be implemented in accordance with the provisions of the Department of the Army Regulation 600-10, and will be subject to the approval of the Secretary of Defense.

9. The proposed changes will be implemented in accordance with the provisions of the Department of the Army Regulation 600-10, and will be subject to the approval of the Secretary of Defense.

10. The proposed changes will be implemented in accordance with the provisions of the Department of the Army Regulation 600-10, and will be subject to the approval of the Secretary of Defense.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> 2688 Item 23b, Film G283 3/27/61 jwk CERTIFICATE OF DEATH 02669 </div>											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 132 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 306 S. Woodyear Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last GUY ----- BARRETTE						4. DATE OF DEATH Month Day Year March 20 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed Soldier				10b. KIND OF BUSINESS OR INDUSTRY Army		11. BIRTHPLACE (County & State, or foreign country) Italy			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Barrette						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 219-32-3560					
17. INFORMATION WW I						Address Clinical Records, VAH, Balto. 18, Md. Ft. Howard Div.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART ATTACK										INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
DUE TO MYOCARDIAL INFARCTION										1 HOUR	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO ARTERIOSCLEROTIC HEART DISEASE										UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
PULMONARY EMPHYSEMA. GOUT											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Nov. 8, 1960, March 20, 61		(County) BALTIMORE		(State) MARYLAND
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 8, 1960 , to March 20, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 20, 1961 , and that death occurred at 9:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Thomas F. Crahan</i> 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/20/61		22d. ADDRESS VAH, BALTO. 18, MD., FT. HOWARD DIVISION	
23b. BURIAL, CREMATION, REMOVAL (Specify) Burial			23c. DATE THEREOF Mar. 23, 1961		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City, town or county) BALTIMORE		(State) MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Forace, 712 E. North Avenue, Balto. Md.						25a. MAR BY REGISTRAR MAR 24 61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

VR A15 (4)
15M 9/60

8388

8388



Joseph, 125 E. North Avenue, Detroit, Mich.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

2689

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02670

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>(9X-3)</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HA New York City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>				d. STREET ADDRESS <u>Bayside, Long Island</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>Bassinger</u> Last <u></u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1863</u>	
9. AGE (In years last birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u></u> Hours <u></u> Min. <u></u>		11. BIRTHPLACE (State or foreign country) <u>Springfield, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Allen Falls Cement Co</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Springfield, N.Y.</u>	
13. FATHER'S NAME <u>Daniel Bassinger</u>				14. MOTHER'S MAIDEN NAME <u>Lydia E. Ly.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>082-14-6728</u>		17. INFORMANT <u>Family Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>fractured pneumothorax, bilateral</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO <u>advanced age - frailty</u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> to <u>March 9</u> , 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>March 9</u> , 19 <u>61</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Jarden</u>				22b. DATE SIGNED <u>3-9-61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial</u>		23b. DATE THEREOF <u>Mar. 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Charles Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Pine Lawn, Long Island, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Townson, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

08030

CERTIFICATE OF DEATH

3888

①

11 8 1923

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G284 4/4/61 iwk

CERTIFICATE OF DEATH

Item 3, Film G-283 3/28/61.cac

Reg. Dist. No.

02671

2690

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hereford				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hereford Rd., Hereford, Md.				d. STREET ADDRESS Hereford Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Louvinia Blackston First Middle Last				4. DATE OF DEATH March 23 1961 Month Day Year					
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1913		9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Webly Greene				14. MOTHER'S MAIDEN NAME Henreitta Green					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 721-18-3684		INFORMANT Address Audry Edmonds Hereford, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leukemias 204.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 3 Yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1-30 , 19 61 , to 3-23 , 19 61 , that I last saw the deceased alive on 3-23 , 19 61 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE C. Herbert Mueller Jr. M.D.				ADDRESS (Street, city or town, state) York Rd. Parkton, Md.				DATE SIGNED	
PHYSICIAN'S NAME (Type) C. Herbert Mueller Jr.				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 3/27/61		22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		22d. LOCATION (City, town, or county) (State) Arbutus Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson Funeral Home Inc.				24a. REC'D BY REGISTRAR DATE MAR 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

153831

CERTIFICATE OF DEATH

1938

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

153831

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2691
CERTIFICATE OF DEATH

02672

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7924 Berk Lane</u>				d. STREET ADDRESS <u>7924 Berk Lane</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Henry Berk</u>				4. DATE OF DEATH <u>March 2nd 1961</u>		5. AGE (In years last birthday) <u>71</u> yrs.	
6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 2, 1889</u>		9. IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Chipper and Corker</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Karl Berk</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Stadder</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>213-09-2495</u>				17. INFORMANT <u>Mrs. Hilda E. Berk</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of colon</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Adenocarcinoma of colon</u> DUE TO (c) <u>Pulmonary emphysema.</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pulmonary emphysema.</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1958</u> to <u>March, 1961</u> , that (I) (we) last saw the deceased alive on <u>2/16 1961</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel Stern</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL STERN</u>				22d. ADDRESS <u>Ridge Rd. Baltimore G. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Stemmers Run, Balto Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 6 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

1232

1036

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2692

CERTIFICATE OF DEATH

02673

1. PLACE OF DEATH 1. NAME OF DECEASED (Type or Print) BENJAMIN BERMAN		2. DATE OF DEATH 3/12/61	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) X Baltimore County 6907 Belair Road Baltimore, 6, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore C. CITY OR TOWN Baltimore (If outside city limits, write RURAL and give township) D. STREET ADDRESS 6907 Belair Road (If rural, give location)	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 10/1/1887
10.A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custom Tailor		10B. KIND OF BUSINESS OR INDUSTRY own business	9. AGE (In years last birthday) 73
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Berman		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Minnie Bensel Berman, wife, above		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 Acute Coronary Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) Parkinson's Disease (B) Ch Coronary Insufficiency II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 3/2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Parkinson's Disease	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. I certify that (I) (this hospital) attended the deceased from 3/2 to 3/9 and that in (my) (our) opinion death occurred at 3A m., from the causes and on the date stated above.	
23A. SIGNATURE A. H. Hornstein ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS 204 E. Biddle St M. D.	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3/16/61	
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAR 16 1961		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Charles E. Schimunek Funeral Home Brehms Lane		ADDRESS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

05830

FORM 100-1

05830

1. NAME (Last, First, Middle Initial)
2. DATE OF BIRTH (Month/Day/Year)
3. SEX (Male/Female)
4. RACE (White/Black/Hispanic/Latina/Asian/Pacific Islander/Other)
5. ETHNICITY (Hispanic/Latina/Asian/Pacific Islander/Other)
6. CURRENT ADDRESS (Street, City, State, ZIP)
7. HOME PHONE (Area Code, Number)
8. WORK PHONE (Area Code, Number)
9. EDUCATION (High School/Diploma/GED/College/University/Postgraduate)
10. OCCUPATION (Job Title)
11. MARITAL STATUS (Single/Married/Divorced/Widowed)
12. NUMBER OF CHILDREN (Total/Under 18)
13. ANNUAL INCOME (Before Taxes)
14. SOURCE OF INCOME (Wages/Self-Employment/Retirement/Other)
15. CRIMINAL RECORD (Yes/No)
16. ALIEN STATUS (Citizen/Permanent Resident/Temporary Resident/Other)
17. SIGNATURE (Printed Name)
18. SIGNATURE (Handwritten Signature)
19. DATE (Month/Day/Year)
20. OFFICIAL USE ONLY (Agency, Division, Office, Date, Initials, Signature)

2693

CERTIFICATE OF DEATH

Reg. Dist. No.

02674

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6651 Chippewa Dr</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>6651 Chippewa Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Better</u> Last <u>Better</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1905</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Salomon Better</u>		14. MOTHER'S MAIDEN NAME <u>Esther ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>26-32-8105</u>		INFORMANT Address <u>Dr. Mrs Anna Better - 6651 Chippewa Drive</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 years</u> (c) <u>1 hour</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7809 Liberty Rd</u>	
20f. (City or town) <u>Baltimore</u>		(County) <u>md</u>		(State) <u>md</u>	
21. I certify that I attended the deceased from <u>Dec 16, 1958</u> to <u>March 4, 1961</u> that I last saw the deceased alive on <u>March 4, 1961</u> and that death occurred at <u>130A</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Benjamin Berdamm</u>		DATE SIGNED <u>March 4, 1961</u>			
PHYSICIAN'S NAME (Type) <u>BENJAMIN BERDANN</u>		<u>Balto 7 md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 5/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Ameno</u>	
22d. LOCATION (City, town, or county) <u>Baltimore, Md</u>		(State) <u>md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Salomon 12102</u>		ADDRESS <u>6000 Reist Road</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(1)

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text appears to be a narrative or medical history.]

(2)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02675**

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa (20)</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>68 Traverse Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Victory Villa (20)</u> d. STREET ADDRESS <u>6 Slipstream Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES RAY BILLINGS</u>				4. DATE OF DEATH Month Day Year <u>March 15, 19 61</u>													
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22, 1948</u>		9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>				11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Carl Billings</u>						14. MOTHER'S MAIDEN NAME <u>Marjorie Dixon</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Carl Billings</u>				Address <u>Same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> <u>936.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally entangled in rope while Subject was Climbing</u>													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Baltimore</u>				20f. (City or town) (County) (State) <u>Baltimore</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>Jack C Collins</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>3-15-61</u>					
EXAMINER'S NAME (Type) <u>JACK C Collins</u>																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>3/16/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Hartsell Funeral Home</u>				22d. LOCATION (City, town, or county) (State) <u>Concord, North Carolina</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdynski</u>						ADDRESS <u>1407 Eastern Ave. (21)</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 20 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2695											
02676											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 39 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie, (Maryland) d. STREET ADDRESS West Drive Box 290W, Rt. 1, Silver Sands, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOHN A. BISESI						4. DATE OF DEATH March 16 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1893		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commission Merchant				10b. KIND OF BUSINESS OR INDUSTRY Merchant House		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Phillips Bisesi						14. MOTHER'S MAIDEN NAME Anna Catanzio					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. WW I 220-03=1389		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG, PRIMARY SITE 163X UNKNOWN Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PULMONARY EMPHYSEMA Operation: 4/18/60 Biopsy of tumor mass, left side of neck: Carcinoma Findings: Metastatic Anaplastic										INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Maryland
21. I certify that (A) (this hospital) attended the deceased from February 5, 1961 to March 16, 1961, that (B) (we) last saw the deceased alive on March 16, 1961, and that death occurred at 8:25 A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Thomas F. Crahan</i> 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/16/61			
22d. ADDRESS VAH, BALTIMORE 18, MD.FT. HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 3/20/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City, town or county) Baltimore			(State) Maryland
24 FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. 715 Light St.						25a. REC'D BY REGISTRAR DATE MAR 21 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Brown</i>			

050730

050730

(M)

(1)

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
[Illegible text follows, including references to "New York", "FBI", and "subject"]

RE: [Illegible]
[Illegible text follows]

DATE: [Illegible]
[Illegible text follows]

BY: [Illegible]
[Illegible text follows, including a signature and date]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
02677										
1. PLACE OF DEATH e. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>BALTO. CTY.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			d. STREET ADDRESS <u>13104 BAYBRIAR RD.</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3104 BAYBRIAR RD.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>BRENDA</u> Middle <u>GAIL</u> Last <u>BOARDWINE</u>					4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1961</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 FEB 1961</u>		9. AGE (In years last birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months <u>32</u> IF UNDER 24 HRS. Hours <u>32</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND (City)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ABRAM BOARDWINE</u>					14. MOTHER'S MAIDEN NAME <u>MELVA KESTNER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MELVA K. BOARDWINE 3104 BAYBRIAR RD.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>763.0</u> DUE TO <u>BRONCHIOLITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>PNEUMONIA - BRONCHIAL -</u> (c) <u>—</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NO INJURY</u>							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>M B Davis</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>M. B. DAVIS, MD</u>					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>3-17-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVER BRIDGE CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>HOLTON WASHINGTON CTY, VA.</u>	
23. FUNERAL DIRECTOR ADDRESS <u>ULLRICH FUNERAL HOME 2112 DUNDALK AVE</u>					24a. REC'D BY REGISTRAR DATE <u>MAR 15 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

2038304XV4

08033

08033

UNITED STATES
DEPARTMENT OF HEALTH



RECEIVED

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

02678

2697

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Laura M. Borton</u>				4. DATE OF DEATH <u>Mar. 16, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 1, 1869</u>	
9. AGE (In years last birthday) <u>91</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Phil. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Zachary Faunce</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ella Jackaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>199-03-9367</u>		17. INFORMANT Address <u>J. Howard Borton-213 Westowne Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized arteriosclerosis -</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH —	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN 1961</u> , to <u>MARCH 16, 1961</u> , that I last saw the deceased alive on <u>MARCH 14, 1961</u> , and that death occurred at <u>12:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6014 EDMONDSON, BALTIMORE 21210</u> DATE SIGNED <u>3/16/61</u>							
ACTUAL SIGNATURE <u>J. Nelson McKey</u> PHYSICIAN'S NAME (Type)				M.D. <u>6014 EDMONDSON, BALTIMORE 21210</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 20, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harleigh Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Camden New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller Inc.</u>				ADDRESS <u>-2431 E. Oliver St.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. **02679**

2698

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. LENGTH OF STAY IN 1b 8 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1721 LESLIE RD.				d. STREET ADDRESS 1721 LESLIE RD			
3. NAME OF DECEASED (Type or print) First Middle Last LOUISA E. BRADFORD				4. DATE OF DEATH Month Day Year MAR. 10 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 28, 1884	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ROBERT OMPTEDA				14. MOTHER'S MAIDEN NAME ELIZABETH (MAIDEN NAME) NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT J.S. BRADFORD				Address 1903 QUEENS WAY (22)			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease 443X DUE TO (Fibrillation) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan - , 19 50 , to March 10 , 19 61 , that I last saw the deceased alive on March 9 , 19 61 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 E. CHASE ST. BALTO. MD. DATE SIGNED 3/13/61 ACTUAL SIGNATURE Louis Krause M.D. PHYSICIAN'S NAME (Type) LOUIS KRAUSE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/14/61			
22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL				22d. LOCATION (City, town, or county) (State) BALTO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE G.W. Hoffmann				ADDRESS 3218 HUDSON ST.			
24a. REC'D BY REGISTRAR MAR 14 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05034

CERTIFICATE OF DEATH

2008

1. Name of deceased: [Illegible]

2. Sex: [Illegible]

3. Date of birth: [Illegible]

4. Date of death: [Illegible]

5. Place of death: [Illegible]

6. Cause of death: [Illegible]

7. Signature of physician: [Illegible]

8. Signature of registrar: [Illegible]

9. Date of registration: [Illegible]

10. Place of registration: [Illegible]

2699

CERTIFICATE OF DEATH

Reg. Dist. 02680

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>7 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3208 McJANE WAY</u>				d. STREET ADDRESS <u>13208 McJANE WAY</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARETHA BRANDENBURG</u>				4. DATE OF DEATH Month Day Year <u>MARCH 28 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15, 1970</u>		9. AGE (In years lost birthday) <u>90</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u> ✓	
13. FATHER'S NAME <u>- GARBER</u>				14. MOTHER'S MAIDEN NAME <u>-</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>FREDA NIEBUHR</u> Address <u>3208 McJANE WAY</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 422.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>28 March 1961</u> , that I last saw the deceased alive on <u>28 March 1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Baermann</u> M.D.				ADDRESS (Street, city or town, state) <u>3401 Dundalk Avenue Dundalk 22, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>W. Baermann</u>				DATE SIGNED <u>DR. W. E. BAERMANN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>MAR 31, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOMES, DUNDALK, MD.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>APR 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2700

CERTIFICATE OF DEATH

Reg. Dist. No.

02681

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ivy Hall Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LYDIA</u> Middle <u>BRESNICK</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 15, 1895</u>	
9. AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR Months <u>65</u> Days <u>65</u> Hours <u>65</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Gellert</u>				14. MOTHER'S MAIDEN NAME <u>Emelia Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Gilbert V. Bresnick 6104 Springwood Ct. 6</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma - primary site undetected</u> DUE TO <u>1999-2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>- Carcinoma - widespread metastases</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bischoff's Gangrene - left foot</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 22</u> , 19 <u>61</u> , to <u>March 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>61</u> , and that death occurred at <u>11 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Wm. A. Rodgers</u> M.D. <u>815 Eastern Ave.</u> <u>3-1-61</u>				PHYSICIAN'S NAME (Type) <u>Wm. A. Rodgers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-4-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evan. Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Stemmers Run, Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u> ADDRESS <u>7401 Belair Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

2000

05081

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. RELIGION</p> <p>10. EDUCATION</p> <p>11. SERVICE</p> <p>12. GRADE</p> <p>13. PAY</p> <p>14. EMPLOYER</p> <p>15. ADDRESS</p> <p>16. CITY</p> <p>17. STATE</p> <p>18. ZIP</p> <p>19. COUNTY</p> <p>20. TOWN</p> <p>21. VILLAGE</p> <p>22. DISTRICT</p> <p>23. PARISH</p> <p>24. CHURCH</p> <p>25. SCHOOL</p> <p>26. HOSPITAL</p> <p>27. NURSING HOME</p> <p>28. HOME</p> <p>29. OTHER</p> <p>30. DATE OF DEATH</p> <p>31. TIME OF DEATH</p> <p>32. PLACE OF DEATH</p> <p>33. CAUSE OF DEATH</p> <p>34. MANNER OF DEATH</p> <p>35. SIGNATURE OF DECEASED</p> <p>36. SIGNATURE OF WITNESSES</p> <p>37. SIGNATURE OF PHYSICIAN</p> <p>38. SIGNATURE OF CLERGY</p> <p>39. SIGNATURE OF JUDGE</p> <p>40. SIGNATURE OF NOTARY</p> <p>41. SIGNATURE OF REGISTRAR</p> <p>42. SIGNATURE OF CLERK</p> <p>43. SIGNATURE OF ASSISTANT CLERK</p> <p>44. SIGNATURE OF DEPUTY CLERK</p> <p>45. SIGNATURE OF DEPUTY ASSISTANT CLERK</p> <p>46. SIGNATURE OF DEPUTY DEPUTY ASSISTANT CLERK</p> <p>47. SIGNATURE OF DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p> <p>48. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p> <p>49. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p> <p>50. SIGNATURE OF DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY DEPUTY ASSISTANT CLERK</p>	
---	--

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2701

CERTIFICATE OF DEATH

02660

Item 1c, Film G284

4/6/61

Item 2 Film G284

4/7/61

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Brother Sebastian, Dacius (Allgeier)		4. DATE OF DEATH Month March Day 31 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1889
9. AGE (In years last birthday) 71		IF UNDER 1 YEAR: Months 71 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brother Teacher		10b. KIND OF BUSINESS OR INDUSTRY Catholic Order of Christian Bros.	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Allgeier		14. MOTHER'S MAIDEN NAME Lita Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 610X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral hydronephrosis & urinary retention DUE TO (c) Benign prostatic hypertrophy			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 28 19 61 , to Mar. 31 19 61 , that (I) (we) last saw the deceased alive on Mar. 31, 1961 , and that death occurred at 625 M, from the causes and on the date stated above.			
22a. SIGNATURE H. I. Cholmondeley		22b. DATE 4/1/61	
22c. PHYSICIAN'S NAME (Type) H. I. Cholmondeley		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 4, 1961	
23c. NAME OF CEMETERY OR CREMATORY Christian Brothers Cemetery		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO.,		25a. REC'D BY REGISTRAR APR 4 '61	
ADDRESS Riverdale, Maryland.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

0141

I

2

13p

00000

CERTIFICATE OF DEATH

2501

DEPARTMENT OF HEALTH
STATE OF NEW YORK
BUREAU OF VITAL STATISTICS
ALBANY, N. Y.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2702

02682

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 30 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. STREET ADDRESS 2820 Brighton Street			
3. NAME OF DECEASED (Type or print) STEPHEN B. BROWN First Middle Last Served As: STEPHEN B. BROWN				4. DATE OF DEATH Month MARCH Day 19 Year 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/11/01	
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stephen Brown				14. MOTHER'S MAIDEN NAME Lucy Watts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW II				16. SOCIAL SECURITY NO. WW II			
17. INFORMANT Clin. Rec. VAH, Balto. Md. Ft. Howard Division				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) MASSIVE PULMONARY HEMORRHAGE DUE TO CARCINOMA LEFT LUNG WITH METASTASIS TO RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 162 X DUE TO Collapsed Vertebra L-I						INTERVAL BETWEEN ONSET AND DEATH Sudden 6 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Collapsed Vertebra L-I							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that My (this hospital) attended the deceased from Feb. 17 1961 to March 19 1961 , that (X) (we) last saw the deceased alive on March 19 1961 , and that death occurred at 7:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Crahan M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/20/61	
22c. PHYSICIAN NAME (Type) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VAH, Balto. Md. Ft. Howard Division			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-23-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Charles G. Cooper ADDRESS 510 Carrollton Ave. Baltimore, Maryland				25a. REC'D BY REGISTRAR DATE MAR 24 '61		25b. REGISTRAR'S SIGNATURE William L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

38030

38030

4



[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2703

02683

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>29 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>338 South Stricker Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wallace P Bruce</u>				4. DATE OF DEATH Month <u>3</u> Day <u>10</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 30, 1896</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>For self</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, Balto.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John M. Bruce</u>			
14. MOTHER'S MAIDEN NAME <u>Louise C. Schramm</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMATION <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> (b) <u>Artherosclerotic Cardiovascular Disease</u> (c) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>jaundice of unknown etiology</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>jaundice of unknown etiology</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 8, 1961</u> to <u>March 10, 1961</u> that (I) (we) last saw the deceased alive on <u>March 10, 1961</u> and that death occurred at <u>7:12 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Bruno Radauskas</u>				22b. DATE SIGNED <u>3/10/1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		23d. LOCATION (City, town or county) (State) <u>3801 Frederick Ave</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 13 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

M

I

1

BP

10082

10082



(I)

John M. Jones
for self
James C. Johnson

Comp. for head of
the California State

for the purpose of

10082

James C. Johnson
for self
John M. Jones
10082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
#

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2704
CERTIFICATE OF DEATH
02684

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4601 Kenwood Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Brueckner Last Brueckner		4. DATE OF DEATH Month 3 Day 2 Year 1961	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1890
9. AGE (In years lost birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 2 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Zabel		14. MOTHER'S MAIDEN NAME Margaret Schwartz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Casper J. Brueckner		Address 4713 Ridgeway Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH many yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-1 1960 to 3-2 1961 , that (I) (we) last saw the deceased alive on 2-13 1961 , and that death occurred at 10PM , from the causes and on the date stated above.			
22a. SIGNATURE Max R. English		22b. DATE SIGNED 3-3-61	
22c. PHYSICIAN'S NAME (Type) Max R. English M.D.		22d. ADDRESS 5713 Belair Rd. Balto. 6.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-1961	
23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd.		25a. REC'D BY REGISTRAR DATE MAR 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOS
may be
TO FUNE

VS A15 (4)
15M 9/55

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
ined by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely fill
ould be detached for use as the burial-transit permit. Then please remove carbon papers.

after death: Page 4

by the funeral director,
2 should be filed with

2705

CERTIFICATE OF DEATH

Reg. Dist. No. 02685

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chapel Hill Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle BUCKLEY Last		4. DATE OF DEATH Month March Day 29 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1883
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Richard M. Forbes		Address 1432 Park Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Recurrent) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 7- , 1960, to March - 29 , 1961, that I last saw the deceased alive on March - 19 , 1961, and that death occurred at 4 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7108-LIBERTY HEIGHTS AVE.			
ACTUAL SIGNATURE Earl L. Chambers		M.D. Baltimore - 7-Maryland	
PHYSICIAN'S NAME (Type) EARL-L-CHAMBERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 1, 1961	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.		ADDRESS 1217 St. Paul Street	
24a. REC'D BY REGISTRAR APR 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

Pages

72 hours after death.

prior to burial, at

the time

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02686

2706

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. LENGTH OF STAY IN 1b <u>2 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William P. Burlage</u>				4. DATE OF DEATH Month Day Year <u>3 1 1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/18/84</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALT. CITY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Burlage</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Kohlman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-05-8906</u>			
17. INFORMANT <u>SISTER-M-CELESTE - STELLA MARIS HOSPICE</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/17</u> , 19 <u>60</u> , to <u>3/1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2/25</u> , 19 <u>61</u> , and that death occurred at <u>9 A. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Mahon</u> M.D.				ADDRESS (Street, city or town, state) <u>602 E Joppa Rd. Towson & MD.</u>			
PHYSICIAN'S NAME (Type) <u>R. J. MAHON MD</u>				DATE SIGNED <u>3/1/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE - MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM COOK-TOWSON, INC - TOWSON - MD</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton E. Howard</u>	

105524

CERTIFICATE OF DEATH

0070

[Faint, illegible text, likely bleed-through from the reverse side of the document]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2707

02687

1. NAME OF DECEASED (Type or Print) Daisy A. Burns			2. DATE OF DEATH 3-27-61		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>Baltimore County Catonsville 28</i> 090 Summit Nursing Home 98 Smithwood Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> c. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> d. STREET ADDRESS (If rural, give location) <i>3402 Mayfair Road</i>		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 18, 1882	9. AGE (In years last birthday) 78	If Under 1 Year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ? Scott			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT ADDRESS Mr. Wm. T. Burns - 3402 Mayfair Road		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 420.0 <i>arteriosclerotic heart disease</i> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>generalized arteriosclerosis</i> DUE TO (C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT 21a. TIME OF INJURY (Month) (Day) (Year) (Hour) 21b. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21c. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>3-17-61</i> to <i>3-17-61</i> and that in (my) (our) opinion death occurred at <i>7:01</i> m., from the causes on and on the date stated above.					
23a. SIGNATURE <i>Mary S. Simpf</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.			23b. ADDRESS <i>2605 Edmonson Ave</i>		23c. DATE SIGNED <i>3-18-61</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3-21-61	24c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		24d. LOCATION (City, town, or county) (State) Baltimore, Maryland
25a. DATE REC'D BY HEALTH DEPT. MAR 28 1961		25b. NAME OF REGISTRAR <i>Arthur S. Haines</i>		25c. FUNERAL DIRECTOR ADDRESS <i>John J. Tickner & Son North & Penna Aves</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper's. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 15M 9/60

10000

10000

M

1. NAME OF PARTY
2. DATE
3. ADDRESS
4. CITY
5. STATE
6. ZIP
7. OCCUPATION
8. EDUCATION
9. MARITAL STATUS
10. NUMBER OF CHILDREN
11. SOURCE OF INCOME
12. TYPE OF HOUSING
13. TYPE OF VEHICLE
14. TYPE OF TRAVEL
15. TYPE OF COMMUNICATION
16. TYPE OF RECREATION
17. TYPE OF DIET
18. TYPE OF CLOTHING
19. TYPE OF PERSONAL CARE
20. TYPE OF SOCIAL LIFE
21. TYPE OF RELIGION
22. TYPE OF POLITICAL BELIEFS
23. TYPE OF ETHNICITY
24. TYPE OF RACE
25. TYPE OF SEX
26. TYPE OF AGE
27. TYPE OF HEIGHT
28. TYPE OF WEIGHT
29. TYPE OF HAIR
30. TYPE OF EYES
31. TYPE OF SKIN
32. TYPE OF BLOOD TYPE
33. TYPE OF ALLERGIES
34. TYPE OF MEDICATIONS
35. TYPE OF SURGERIES
36. TYPE OF CHRONIC DISEASES
37. TYPE OF ACUTE DISEASES
38. TYPE OF TRAUMAS
39. TYPE OF INJURIES
40. TYPE OF DEATHS
41. TYPE OF CAUSES OF DEATH
42. TYPE OF FUNERALS
43. TYPE OF BURIALS
44. TYPE OF CREMATIONS
45. TYPE OF DONATIONS
46. TYPE OF CHARITABLE CONTRIBUTIONS
47. TYPE OF VOLUNTARY SERVICE
48. TYPE OF CIVIL DISOBEDIENCE
49. TYPE OF CRIMINAL RECORD
50. TYPE OF LEGAL PROCEEDINGS
51. TYPE OF COURT CASES
52. TYPE OF JUDICIAL DECISIONS
53. TYPE OF APPEALS
54. TYPE OF SUPREME COURT DECISIONS
55. TYPE OF CONSTITUTIONAL DECISIONS
56. TYPE OF STATUTE DECISIONS
57. TYPE OF REGULATORY DECISIONS
58. TYPE OF ADMINISTRATIVE DECISIONS
59. TYPE OF EXECUTIVE DECISIONS
60. TYPE OF LEGISLATIVE DECISIONS
61. TYPE OF JUDICIAL REVIEW
62. TYPE OF JUDICIAL CHECKS
63. TYPE OF JUDICIAL BRANCHES
64. TYPE OF JUDICIAL SYSTEMS
65. TYPE OF JUDICIAL PROCESSES
66. TYPE OF JUDICIAL PROCEDURES
67. TYPE OF JUDICIAL PRACTICES
68. TYPE OF JUDICIAL ETHICS
69. TYPE OF JUDICIAL STANDARDS
70. TYPE OF JUDICIAL VALUES
71. TYPE OF JUDICIAL PRINCIPLES
72. TYPE OF JUDICIAL DOCTRINES
73. TYPE OF JUDICIAL THEORIES
74. TYPE OF JUDICIAL PHILOSOPHIES
75. TYPE OF JUDICIAL IDEOLOGIES
76. TYPE OF JUDICIAL MOVEMENTS
77. TYPE OF JUDICIAL TRENDS
78. TYPE OF JUDICIAL CHALLENGES
79. TYPE OF JUDICIAL CRITICISMS
80. TYPE OF JUDICIAL DEFENSES
81. TYPE OF JUDICIAL SUPPORTS
82. TYPE OF JUDICIAL OPPOSITIONS
83. TYPE OF JUDICIAL ALLIANCES
84. TYPE OF JUDICIAL ENEMIES
85. TYPE OF JUDICIAL FRIENDS
86. TYPE OF JUDICIAL ADVERSARIES
87. TYPE OF JUDICIAL COLLEAGUES
88. TYPE OF JUDICIAL SUBORDINATES
89. TYPE OF JUDICIAL SUPERIORES
90. TYPE OF JUDICIAL PEERS
91. TYPE OF JUDICIAL MENTORS
92. TYPE OF JUDICIAL MENTEEES
93. TYPE OF JUDICIAL ADVISORS
94. TYPE OF JUDICIAL COUNSELORS
95. TYPE OF JUDICIAL CONSULTANTS
96. TYPE OF JUDICIAL EXPERTS
97. TYPE OF JUDICIAL SPECIALISTS
98. TYPE OF JUDICIAL GENERALISTS
99. TYPE OF JUDICIAL POLYVALENTS
100. TYPE OF JUDICIAL OMNIBUS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02688**

2708

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>315 E. Timonium Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. John George Chenoweth, Jr.</u>				4. DATE OF DEATH Month Day Year <u>March 18th 19 61</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1909</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Broker N.Y. Stock</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Exchange</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John G. Chenoweth, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Fuller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-03-5510</u>		17. INFORMANT <u>Mrs. Lillian H. Chenoweth</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (c) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> (c) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Charles O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/20/61</u>	
EXAMINER'S NAME (Type) <u>Charles O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 21 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12508

12508

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. JONES		M		45		JAN 15 1905		BALTIMORE, MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
Carpenter		Myocardial Infarction		Natural		JAN 20 1950		BALTIMORE, MD	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE DATE		MARRIAGE PLACE		MARRIAGE TYPE	
JAMES H. JONES		MARY J. JONES		JAN 15 1925		BALTIMORE, MD		Civil	
EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		MILITARY SERVICE	
High School		Roman Catholic		Democratic		None		None	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
None		None		None		None		None	
SIGNS AND SYMPTOMS		PHYSICIAN'S STATEMENT		LABORATORY TESTS		X-RAY EXAMINATION		AUTOPSY	
Sudden death		No signs of trauma		Normal		Normal		None	
FINDINGS		CONCLUSIONS		REMARKS		SIGNATURE OF EXAMINER		DATE	
No signs of trauma		Myocardial Infarction		None		JAMES H. JONES		JAN 20 1950	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
X
I
B
2709
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02689

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Parkton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Millers Lane				d. STREET ADDRESS Millers Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lawrence Middle Elijah Last Chilcoat				4. DATE OF DEATH Month 3 Day 8 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-23-1891	
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Chilcoat				14. MOTHER'S MAIDEN NAME Laura Guyton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-36-0022		17. INFORMANT Mrs. May Chilcoat	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Arterio-sclerosis DUE TO (c) Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Feb. 1960 to Mar. 9, 1961 , that (I) (we) last saw the deceased alive on Mar. 7, 1961 , and that death occurred at 9 P. M. from the causes and on the date stated above. 22a. SIGNATURE A. M. France 22c. PHYSICIAN'S NAME (Type) A. M. FRANCE 22d. ADDRESS Parkton, Md 22b. DATE SIGNED 3/9/61 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3-12-61		23b. DATE THEREOF 3-12-61		23c. NAME OF CEMETERY OR CREMATORY Hereford Assembly of God Parkton,		23d. LOCATION (City, town, or county) (State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md.				25a. REC'D BY REGISTRAR MAR 13 '61		25b. REGISTRAR'S SIGNATURE Charles S. France	

03000

03000

COIN-AGE OF DEATH

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

03000

2710

CERTIFICATE OF DEATH

Reg. Dist. No. 02630

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crawings Mills P.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crawings Mills - P.O.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at his home</u>		d. STREET ADDRESS <u>Garrison Forest & Caves Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Edward Cockey</u>		4. DATE OF DEATH <u>March 19 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/11-1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Public Relations - Tomen-Mys.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles E. Cockey</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Cropper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes WWII</u>		16. SOCIAL SECURITY NO. <u>159-10-2988</u>	
17. INFORMANT <u>Mrs Louise Ames</u>		Address <u>819 Park Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PROSTATIC CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>NOVEMBER 1960</u> to <u>MARCH 1961</u> , that I last saw the deceased alive on <u>MARCH 18 1961</u> , and that death occurred at <u>1:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Carlton L. Sexton</u> M.D.		ADDRESS (Street, city or town, state) <u>819 PARK AVE.</u> DATE SIGNED <u>MARCH 19, 1961</u>	
PHYSICIAN'S NAME (Type) <u>CARLTON L. SEXTON</u>		<u>BALTIMORE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 21/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenview</u>	22d. LOCATION (City, town, or county) (State) <u>Likesville md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sheward Moore</u>		ADDRESS <u>108 W York Balto</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
2711					02691					
1. PLACE OF DEATH a. COUNTY Baltimore County					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland					b. COUNTY Harford					
c. LENGTH OF STAY IN 1b 5 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whiteford					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital					d. STREET ADDRESS Whiteford, Maryland					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First Middle Last JAMES R. COMBS					4. DATE OF DEATH Month Day Year 3 7 19 61					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. 2. 1894		9. AGE (In years last birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME GEORGE HARVEY					14. MOTHER'S MAIDEN NAME EDITH SCARBER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown					16. SOCIAL SECURITY NO. —					
17. INFORMANT Hospital Records, Mt. Wilson State Hospital					Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 002X Far advanced bilateral cavity pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculous pericarditis. Emphysema, compensated. INTERVAL BETWEEN ONSET AND DEATH 12 yrs										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-2-1961 to 3-7-1961, that (I) (we) last saw the deceased alive on 3-7-1961, and that death occurred at 12:25 p.m. from the causes and on the date stated above.										
22a. SIGNATURE W. Newcomer					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3.7.1961			
22c. PHYSICIAN'S NAME (Type) Wn. Newcomer, M.D., Superintendent					22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.					
23a. BURIAL, CREMATION, OR OTHER (Specify) Burial			23b. DATE THEREOF 3-10-61		23c. NAME OF CEMETERY OR CREMATORY FELLOWSHIP			23d. LOCATION (City, town, or county) (State) RYLESVILLE, MD.		
24. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins					ADDRESS DELTA, PA.		25a. REC'D BY REGISTRAR MAR 10 '61		25b. REGISTRAR'S SIGNATURE Charles S. Evans	

I

M

002

2

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6282 3-14-61 et

2712

CERTIFICATE OF DEATH

Reg. Dist. No. 02692

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chattanooga</u> c. LENGTH OF STAY IN 1b <u>1 day?</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chattanooga</u> d. STREET ADDRESS <u>1231 Maple Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Connolly</u> Last <u>Connolly</u>		4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 6 - 1883</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9c. AGE (In years lost birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	10c. AGE (In years lost birthday) <u>77</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Fredrick Weisenborn</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1231 Maple Ave (27)</u>	
17. INFORMANT <u>Mr. James E. Connolly</u>		Address <u>1231 Maple Ave (27)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular atherosclerosis</u> DUE TO (c) <u>5 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>60</u> , to <u>March 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb. 28</u> , 19 <u>61</u> , and that death occurred at <u>5:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Nelson McKay</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>6014 Edmondson Ave Balt 2124 3/6/61</u>	
PHYSICIAN'S NAME (Type) <u>J. NELSON MCKAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>3801 Frederick Ave.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Bowman Fox</u>		ADDRESS <u>901-3 Hollins St</u>	
24a. REC'D BY REGISTRAR <u>MAR 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

05050

CENTRAL DEATH

5175

1947 M 20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2713

CERTIFICATE OF DEATH

02693

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>2004-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>3yr5mt15dys</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltim ore</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgina Florian Conner</u>				4. DATE OF DEATH Month Day Year <u>March 19 1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1889</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waitress</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>Texas</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Charles Florian</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Sterling</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>40-26-4327</u>			
17. INFORMANT <u>Records; SPRING GROVE STATE HOSPITAL</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (c) <u>obesity</u> (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>obesity</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>1957</u>				20g. (County) <u>March 19</u>		20h. (State) <u>1961</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 4</u> to <u>March 19</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>March 19</u> , 19 <u>61</u> , and that death occurred at <u>1:20</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D.				22b. DATE SIGNED <u>3- -61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>			
23a. BURIAL, CREMATION, REBURYAL (Specify) <u>Burial 3/31/61</u>		23b. DATE THEREOF <u>3/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>		23d. LOCATION (City, town or county) (State) <u>230001 Frederick</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Foley</u>				25a. REC'D BY REGISTRAR <u>APR 3 61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

10800

8173



[Faint, illegible handwritten text at the bottom of the page, possibly a signature or date.]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2714

CERTIFICATE OF DEATH

02694

Item 13 File 6242 5/17/61 et

1. PLACE OF DEATH a. COUNTY Balto. Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md		b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ebenezer Road		d. STREET ADDRESS Ebenezer Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret P. Crouch		4. DATE OF DEATH Month Day Year 3 8 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1869	9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Joshua Crouch League		14. MOTHER'S MAIDEN NAME Annie Rollins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John W. Crouch 27 Ceader Ave. Towson Ms.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO CARDIAC FAILURE (b) ARTERIO-SCLEROTIC HEART (c) DUE TO DISEASE WITH HYPERTENSION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 WEEKS 8 YRS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT 1959 to MAR 8 1961, that (I) (we) last saw the deceased alive on MAR 8 1961, and that death occurred at 6 P. M. from the causes and on the date stated above.					
22a. SIGNATURE Joseph Miceli		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/10/61	
22c. PHYSICIAN'S NAME (Type) JOSEPH MICELI, M.D.		22d. ADDRESS 108 S. TAYLOR AVE BALTO. 21, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-11-1961		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	
23d. LOCATION (City, town, or county) (State) Balto. Co. Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Rd #6.		25a. REC'D BY REGISTRAR DATE MAR 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

0800

STATE OF CALIFORNIA

1974

11

11

11

1

X
I
0
1
8p

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

X
I
0
1
8p

2715

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02695

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1521 Barrett Rd. #7		d. STREET ADDRESS 1521 Barrett Rd. #7	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anthony Middle J. Last Culotta		4. DATE OF DEATH Month March Day 2 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1899
9. AGE (In years last birthday) 62yr B.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) guard		10b. KIND OF BUSINESS OR INDUSTRY Pinkerton Dect. Agy. Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Philip Gugliotta		14. MOTHER'S MAIDEN NAME Josephine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215 32 8185	
17. INFORMANT (daughter) Mrs. Josephine Bumba		Address 924 Elmridge Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) Coronary artery occlusion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from April 21, 19 54 to March 27, 19 61 that (I) (we) last saw the deceased alive on Feb. 27, 19 61 , and that death occurred at 9:00A.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Harry L. Knipp</i>		22b. DATE SIGNED 3/2/61	
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M. D.		22d. ADDRESS 4116 Edmondson Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DATE MAR 6 '61	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kears</i>	

3715

CHARTER OF STATE

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

1885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2716											
CERTIFICATE OF DEATH											
Item 9 Film 6283 3/30/61 mh											
02696											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 22yr10mth10dys				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville, Maryland d. STREET ADDRESS Seminary Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) (Betty) ELIZABETH A. Dedal				4. DATE OF DEATH March 21 1961				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 26, 1920		9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME George Dedal				14. MOTHER'S MAIDEN NAME Florence Scott			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conges tive heart failure 353.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Status convulsivus (c) Idiopathic epilepsy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1 1956 to March 21 1961 , that (I) (we) last saw the deceased alive on March 21 1961 and that death occurred at 6:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachslar M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 3-21-61				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Mar. 24, 1961		23c. NAME OF CEMETERY OR CREMATORY Sater's Baptist Cemetary		23d. LOCATION (City, town or county) (State) Lutherville, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				ADDRESS				25a. REC'D BY REGISTRAR MAR 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

M

2316

I

x

John Burns' Sons, Townson, Maryland
Burial Mar. 24, 1901 Peter's Baptist Cemetery
Inchville, Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02697

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex #21</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>405 Worton Road</u>		d. STREET ADDRESS <u>405 Worton Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DANIEL JOSEPH DELEA SR.</u>		4. DATE OF DEATH <u>March 11, 19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30, 1892</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Delea</u>		14. MOTHER'S MAIDEN NAME <u>Ann McHale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>212-03-1711</u>	
17. INFORMANT <u>Delores Warnecker</u>		Address <u>321 A Savannah Ave, #21</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>A-S-C-V Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 Min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis, MD.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. Bruzdziński</u>		24a. REC'D BY REGISTRAR <u>DATE</u>	
ADDRESS <u>1407 Eastern Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2718

CERTIFICATE OF DEATH

02698

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Box 184		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lester Middle Lee Last Disney				4. DATE OF DEATH Month March Day 16 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1871		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance man (ret)			10b. KIND OF BUSINESS OR INDUSTRY P. R. R.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Andrew J. Disney				14. MOTHER'S MAIDEN NAME Harriett Redmiles			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease							
442X } DUE TO (b) Arteriosclerosis, generalized and severe							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. } DUE TO (c) Nephrosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 11, 1961 to March 16, 1961 , that (I) (we) last saw the deceased alive on March 16, 1961 , and that death occurred at 2:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE <i>Stella Wachslar</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		22b. DATE SIGNED 3-16-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 18th March '61		23c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery		23d. LOCATION (City, town or county) (State) Anne Arundel Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. J. Long</i>				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR DATE MAR 20 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hana</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

05830

05830

(M)

(T)

Handwritten notes and stamps at the bottom of the page, including a date stamp "MAR 20 1961" and a signature.

Arthur S. Kraus

VR A15 (4)
15M 9/60

00000

2173

M

T

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper's. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2720

02700

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 102 E. SUSQUEHANNA AVE.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 102 E. SUSQUEHANNA AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) JOHN PAUL EATON				4. DATE OF DEATH Month MARCH Day 13 Year 1961											
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 20, 1904		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY BALTO. METRO. DIS				11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME SAMMUEL EATON				14. MOTHER'S MAIDEN NAME CATHERIN HOFMEISTER											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service) NONE				16. SOCIAL SECURITY NO. A 217-03-2588		17. INFORMANT FAMILY RECORDS				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerotic Cardio-Renal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH Sudden 3 yrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from March 10, 1961 to March 13, 1961 , that (I) (we) last saw the deceased alive on March 10, 1961 , and that death occurred at 9:15 M, from the causes and on the date stated above.															
22a. SIGNATURE Charles H. Donnell M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3/16/61		23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK				23d. LOCATION (City, town or county) PARKVILLE (State) MD.					
24. FUNERAL DIRECTOR'S SIGNATURE John Burns, Towson, Maryland				ADDRESS				25a. REC'D BY REGISTRAR MAR 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

(M)

(I)

BALTIMORE

TORSON

102 E. SUSQUEHANNA AVE.

JOHN

PAUL

BATCH

MARCH

102 E. SUSQUEHANNA AVE.

TORSON

MARYLAND

BALTIMORE

MALE WHITE

X

JUNE 20, 1907

26

TRUCK DRIVER

BALTO. METRO. DIS.

MARYLAND

USA

SAMUEL BATCH

CATHERINE HOLMISTER

NO HOME

217-03-2588

FAMILY RECORDS

BURIAL 2/6/61 HONOLAND MEMORIAL PARK BAREVILLE MD.

John James Thomas Murphy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
2721
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02701

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 27 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) W.M. Raymond First W. Middle Ehlers Last				4. DATE OF DEATH Month March Day 29 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1881	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanical eng.				10b. KIND OF BUSINESS OR INDUSTRY RET.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME unknown LEWIS EHLERS				14. MOTHER'S MAIDEN NAME unknown ISSAC			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cardiac failure DUE TO (c) Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 14, 19 61 to March 29, 19 61 , that (I) (we) last saw the deceased alive on March 29, 19 61 , and that death occurred at 3:00 P. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-29-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/1/61		23c. NAME OF CEMETERY OR CREMATORY WOODLAWN		23d. LOCATION (City, town, or county) (State) BALTO. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Smith, Son Co. 28				ADDRESS 28		25a. REC'D BY REGISTRAR MAR 30 61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Thayer			

05201

CERTIFICATE OF DEATH

1951

DEPARTMENT OF HEALTH
STATE OF NEW YORK
OFFICE OF VITAL RECORDS

FILE NO. 100-100000
DATE OF DEATH

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

1
M
X
I
O
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
X
I
O
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2722
CERTIFICATE OF DEATH
02702

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 424 Greenlow Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 424 Greenlow Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Catherine L. Essert		4. DATE OF DEATH Month Day Year March 25, 1961 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 26, 1923
9. AGE (In years last birthday) 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Worked	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank L. Essert		14. MOTHER'S MAIDEN NAME Edna T. Hayden	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Edna T. Essert-424 Greenlow Road		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. PATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 DUE TO metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO adenocarcinoma of Intestine PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) see month INTERVAL BETWEEN ONSET AND DEATH about 3 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from about 1936 to 3-25, 1961 , that (I) (we) last saw the deceased alive on 3-23, 1961 , and that death occurred at 7 p.m. from the causes and on the date stated above.			
22a. SIGNATURE G. Highstein M.D.		22b. DATE SIGNED 3-27-61	
22c. PHYSICIAN'S NAME (Type) GUSTAV HIGHSTEIN		22d. ADDRESS 888 W Lombard St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Jackson		25a. REC'D BY REGISTRAR DATE MAR 27 '61	
ADDRESS North Anna Baltimore, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

85708

3373

(M)

(I)

1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02703

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 23yrlmthl6dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 514 SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3701-4 d. STREET ADDRESS 3510 Holmes Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Israel First Middle Last Exler		4. DATE OF DEATH Month Day Year March 31 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) rag picker		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Erey Exler		14. MOTHER'S MAIDEN NAME Hilda Flaxman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Reocdrds: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 903-7 DUE TO acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) cardiovascular disease (a), stating the underlying cause last. DUE TO (c) fracture right femur			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) On 1-29-61 an open reduction and internal fixation with Smith-Peterson nail and McLaughlin Side Plate and screws was performed			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) On 1-19-61 while on the way to the diningroom, patient was knocked down by another pt. sustaining an intertrochanteric frac. of the right femur	
20c. TIME OF INJURY Month, Day, Year 5:00 p.m. 1-19- 19 61		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	
20e. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State) Catonsville 28, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer EXAMINER'S NAME (Type) George M. Kieffer, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 31 61 Address (Street, city, town, or county) 1010 Leeds an	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 4-3-61	22c. NAME OF CEMETERY OR CREMATORY Rosedale	22d. LOCATION (City, town, or country) (State) Balto Md
23. FUNERAL DIRECTOR Jack Lewis Inc ADDRESS 2100 Eutaw Pl		24a. REC'D BY REGISTRAR APR 4 '61 24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

0530

0530

1950
JAN 10
1950

[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. No. 02704

2724

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STEMMERS RUN				c. LENGTH OF STAY IN 1b 9 MONTHS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1817 SUNNYSIDE RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael First FANSLAW Middle LAST				4. DATE OF DEATH Month 3 Day 13 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/11/1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY SHIPYARD		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? RUSSIA <input checked="" type="checkbox"/>							
13. FATHER'S NAME NOT KNOWN				14. MOTHER'S MAIDEN NAME NOT KNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 216-05-1421		17. INFORMANT MRS. EVA WEBB Address 1817 SUNNYSIDE RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suffocation - Suicidal 9779X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 hrs							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack E Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack E Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/15/61		22c. NAME OF CEMETERY OR CREMATORY SCHWARTZ'S		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE B. W. Hoffmann ADDRESS 3218 HUDSON ST. (24)				24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Finner	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, cremation, or removal.

10-10-20

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. EDUCATION</p>	
<p>9. PRESENT RESIDENCE</p>		<p>10. DATE OF DEATH</p>	
<p>11. CAUSE OF DEATH</p>		<p>12. MANNER OF DEATH</p>	
<p>13. SIGNATURE OF EXAMINER</p>		<p>14. SIGNATURE OF WITNESS</p>	
<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF JURY</p>		<p>18. SIGNATURE OF JURY</p>	
<p>19. SIGNATURE OF JURY</p>		<p>20. SIGNATURE OF JURY</p>	
<p>21. SIGNATURE OF JURY</p>		<p>22. SIGNATURE OF JURY</p>	
<p>23. SIGNATURE OF JURY</p>		<p>24. SIGNATURE OF JURY</p>	
<p>25. SIGNATURE OF JURY</p>		<p>26. SIGNATURE OF JURY</p>	
<p>27. SIGNATURE OF JURY</p>		<p>28. SIGNATURE OF JURY</p>	
<p>29. SIGNATURE OF JURY</p>		<p>30. SIGNATURE OF JURY</p>	
<p>31. SIGNATURE OF JURY</p>		<p>32. SIGNATURE OF JURY</p>	
<p>33. SIGNATURE OF JURY</p>		<p>34. SIGNATURE OF JURY</p>	
<p>35. SIGNATURE OF JURY</p>		<p>36. SIGNATURE OF JURY</p>	
<p>37. SIGNATURE OF JURY</p>		<p>38. SIGNATURE OF JURY</p>	
<p>39. SIGNATURE OF JURY</p>		<p>40. SIGNATURE OF JURY</p>	
<p>41. SIGNATURE OF JURY</p>		<p>42. SIGNATURE OF JURY</p>	
<p>43. SIGNATURE OF JURY</p>		<p>44. SIGNATURE OF JURY</p>	
<p>45. SIGNATURE OF JURY</p>		<p>46. SIGNATURE OF JURY</p>	
<p>47. SIGNATURE OF JURY</p>		<p>48. SIGNATURE OF JURY</p>	
<p>49. SIGNATURE OF JURY</p>		<p>50. SIGNATURE OF JURY</p>	
<p>51. SIGNATURE OF JURY</p>		<p>52. SIGNATURE OF JURY</p>	
<p>53. SIGNATURE OF JURY</p>		<p>54. SIGNATURE OF JURY</p>	
<p>55. SIGNATURE OF JURY</p>		<p>56. SIGNATURE OF JURY</p>	
<p>57. SIGNATURE OF JURY</p>		<p>58. SIGNATURE OF JURY</p>	
<p>59. SIGNATURE OF JURY</p>		<p>60. SIGNATURE OF JURY</p>	
<p>61. SIGNATURE OF JURY</p>		<p>62. SIGNATURE OF JURY</p>	
<p>63. SIGNATURE OF JURY</p>		<p>64. SIGNATURE OF JURY</p>	
<p>65. SIGNATURE OF JURY</p>		<p>66. SIGNATURE OF JURY</p>	
<p>67. SIGNATURE OF JURY</p>		<p>68. SIGNATURE OF JURY</p>	
<p>69. SIGNATURE OF JURY</p>		<p>70. SIGNATURE OF JURY</p>	
<p>71. SIGNATURE OF JURY</p>		<p>72. SIGNATURE OF JURY</p>	
<p>73. SIGNATURE OF JURY</p>		<p>74. SIGNATURE OF JURY</p>	
<p>75. SIGNATURE OF JURY</p>		<p>76. SIGNATURE OF JURY</p>	
<p>77. SIGNATURE OF JURY</p>		<p>78. SIGNATURE OF JURY</p>	
<p>79. SIGNATURE OF JURY</p>		<p>80. SIGNATURE OF JURY</p>	
<p>81. SIGNATURE OF JURY</p>		<p>82. SIGNATURE OF JURY</p>	
<p>83. SIGNATURE OF JURY</p>		<p>84. SIGNATURE OF JURY</p>	
<p>85. SIGNATURE OF JURY</p>		<p>86. SIGNATURE OF JURY</p>	
<p>87. SIGNATURE OF JURY</p>		<p>88. SIGNATURE OF JURY</p>	
<p>89. SIGNATURE OF JURY</p>		<p>90. SIGNATURE OF JURY</p>	
<p>91. SIGNATURE OF JURY</p>		<p>92. SIGNATURE OF JURY</p>	
<p>93. SIGNATURE OF JURY</p>		<p>94. SIGNATURE OF JURY</p>	
<p>95. SIGNATURE OF JURY</p>		<p>96. SIGNATURE OF JURY</p>	
<p>97. SIGNATURE OF JURY</p>		<p>98. SIGNATURE OF JURY</p>	
<p>99. SIGNATURE OF JURY</p>		<p>100. SIGNATURE OF JURY</p>	

RECEIVED JUNE 10 1920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
2725
M
090
I

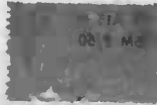
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02705

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville 28 c. LENGTH OF STAY IN 1b 28 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mrs. Bassett's Nursing Home 335 Bloomsbury Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore A.A. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 26 d. STREET ADDRESS 7817 High Point Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard H. Farley		4. DATE OF DEATH Month March Day 2 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10 Hours 30 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home construction	
11. BIRTHPLACE (County & State, or foreign country) Princeton, W.Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henderson Farley		14. MOTHER'S MAIDEN NAME Nannie Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-05-4215H	
17. INFORMANT Mrs. Nora Farley, White Marsh, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 day 1031	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-6-61 , 19 60 , to 3-2-61 , 19 61 , that (I) (we) last saw the deceased alive on 3-4-19 61 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher M.D.		22b. DATE SIGNED 3-4-61	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher, M.D.		22d. ADDRESS 6209 Frederick Rd. Catonsville 28, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-4-61	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town or county) (State) 3310 Taylor Avenue	
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		25a. REC'D BY REGISTRAR MAR 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

05700

2525



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2726

CERTIFICATE OF DEATH

02706

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Harrisonville				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 231A Randallstown, P.O. Liberty Rd.				d. STREET ADDRESS Liberty Road Box 231A Randallstown P.O.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Alice First V. Middle Fee Last				4. DATE OF DEATH Month March Day 5 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1879	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Wienke				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Howard W. Fee, 4605 Wilkens Ave. Balto. 29, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Valvular Heart Disease DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4/61 19 61 to 3/5/61 19 61 , that (I) (we) last saw the deceased alive on 3/5/61 19 61 , and that death occurred at PM , from the causes and on the date stated above.							
22a. SIGNATURE Wm. E. Martin				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wm. E. Martin				22d. ADDRESS Randallstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-9-1961		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Long Byers				ADDRESS 8728 Liberty Road		25a. REC'D BY REGISTRAR DATE MAR 10 '61	
						25b. REGISTRAR'S SIGNATURE William S. Kraus	

M

I

1
ep

Randallstown, Md.

08780

CERTIFICATE OF DEATH

1956

(1)

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2727

02707

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6,				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4304 Necker Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GUY Middle ROLAND Last FISHPAW				4. DATE OF DEATH Month 3 Day 2 Year 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1893		9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 8 Days 24 Hours 13 Mins 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cooper			10b. KIND OF BUSINESS OR INDUSTRY distillery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Levi Fishpaw				14. MOTHER'S MAIDEN NAME Maria Sheeler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. above		17. INFORMANT Hilda T. Fishpaw		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 443X DUE TO Hypertensive Cardiovas. Dis. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) 15y. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pernicious Anaemia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from May 10, 1938 to Mar. 2, 1961 that (I) (we) last saw the deceased alive on Mar. 1, 1961 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Clifford F. Hudson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CLIFFORD F. HUDSON				22d. ADDRESS FORK, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-6-61		23c. NAME OF CEMETERY OR CREMATORY Jessop Methodist		23d. LOCATION (City, town, or county) (State) Sparks, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				25a. REC'D BY REGISTRAR DATE MAR 9 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

03207

CERTIFICATE OF DEATH

03207

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		1950		New York	
Cause of Death		Occupation		Education		Religion		Marital Status		Signature of Physician	
Heart Disease		Teacher		High School		Catholic		Married		[Signature]	
Date of Burial		Place of Burial		Name of Burial Place		Name of Minister		Name of Undertaker		Name of Funeral Home	
1950		New York		St. John's		Rev. J. Smith		J. Doe		J. Doe	

1
M
090
I
2
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2728
CERTIFICATE OF DEATH
02708

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FULLERTON c. LENGTH OF STAY IN TB MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FULLERTON NURSING HOME				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON - 4 d. STREET ADDRESS 1601 PICCADILLY RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA		First FLANAGAN		Last FLANAGAN		4. DATE OF DEATH Month MARCH Day 19 Year 1961	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG-4 1881	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS. Hours 19 Min. 19		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A NATURALIZED					
13. FATHER'S NAME FRANK ADER				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes give number and date of service)		17. INFORMANT CHARLES M. FLANAGAN		Address TOWSON, 601 PICCADILLY RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXSANGUINATION (INTO BOWEL) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) MASSIVE INFARCTION OF BOWEL DUE TO (c) ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 12 HOURS YEARS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) ARTERIOSCLEROTIC HEART DISEASE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/15 1960 to 3/19 1961, that (I) (we) last saw the deceased alive on 3/19 1961, and that death occurred at 9:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Donald L. Somerville M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/19/61	
22c. PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE, M.D.				22d. ADDRESS 25 W. PENNA AVE; TOWSON 4, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-22-61		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD		23d. LOCATION (City, town or county) (State) LOHMEYER WEST VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE W. M. COOK - TOWSON, INC				ADDRESS 7050 YORK RD - TOWSON		25a. REC'D BY REGISTRAR MAR 21 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

05108

8228

M

I

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02709

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Central Avenue		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon d. STREET ADDRESS 11 Central Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last TIMOTHY JOHN FLORENTINA		4. DATE OF DEATH Month Day Year March 14 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Feb. 12, 1961	
9. AGE (In years last birthday) yrs. 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Francis Florentina		14. MOTHER'S MAIDEN NAME Margaret M. Tierney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Francis Florentina, 11 Central Ave. Glyndon, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury In Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		DATE SIGNED 3/15/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 15, 1961	
22c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		22d. LOCATION (City, town, or country) (State) Reisterstown, Md.	
23. FUNERAL DIRECTOR ADDRESS J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '61	
24b. REGISTRAR'S SIGNATURE Carlton S. Kraus			

20 44 34 6 x v 6

THE
HALL

M

1

3733

BALTIMORE

11 Central Avenue

11 Central Avenue

White

White

Feb. 12, 1961

John A. [illegible]

X

W. Bradley King, Jr.

02700

BALTIMORE

BALTIMORE

11 Central Avenue

11 Central Avenue

11 Central Avenue

11 Central Avenue

11 Central Avenue

11 Central Avenue

11 Central Avenue

11 Central Avenue

11 Central Avenue

02700

1
X
M
I
0
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2730

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No 02710

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u>		c. LENGTH OF STAY IN 1b <u>38 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ADA</u> Middle <u>LOKER</u> Last <u>FRANCIES</u>		4. DATE OF DEATH Month <u>march</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 7 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fallston Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Loker</u>		14. MOTHER'S MAIDEN NAME <u>Laura Denbow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-34-0140</u>	
17. INFORMANT <u>William T.M. Frances</u>		Address <u>Baldwin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Coronary Occlusion</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>yes</u> <u>6</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 14, 1923</u> , to <u>Mar 11, 1961</u> , that I last saw the deceased alive on <u>Mar 11, 1961</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter McHammett</u>		ADDRESS (Street, city or town, state) <u>Baldwin</u>	
PHYSICIAN'S NAME (Type) <u>Walter McHammett</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Naugh Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Glenn Arm. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Futz</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 15 '61</u>	
ADDRESS <u>Jarrettsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

08330

CERTIFICATE OF DEATH

08330



Blank certificate form with horizontal lines for text entry.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02712

2731

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton (Fullerton)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Bangert Avenue				d. STREET ADDRESS 24 Bangert Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John First Friesser Middle 18 Last				4. DATE OF DEATH March Month 18 Day 1961 Year			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1876	
9. AGE (In years last birthday) yrs. 84		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Marburg, Austria	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mathias Friesser				14. MOTHER'S MAIDEN NAME Theresia Traxler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Julius M. Friesser, 24 Bangert Ave, Fullerton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition, Senility DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Insufficiency / Congestive failure DUE TO Generalized Arteriosclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 19 59 , to March , 19 61 , that I last saw the deceased alive on March 16 1961 , and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Tyson M.D.				ADDRESS (Street, city or town, state) Kingsville, Md. DATE SIGNED 3-18-61			
PHYSICIAN'S NAME (Type) William A. Tyson, M.D.				Kingsville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-20-61		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Grand Rapids, Michigan	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc., 1050 York Road, Towson				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 21 '61	
				24b. REGISTRAR'S SIGNATURE William L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
X
I
O
1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2732
CERTIFICATE OF DEATH

02713

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b X Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1037 Beechfield Avenue		d. STREET ADDRESS 1037 Beechfield Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle F. Last Fritzges		4. DATE OF DEATH Month March Day 27 , Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Fritzges		14. MOTHER'S MAIDEN NAME Margaret Sussen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. AAA	
17. INFORMANT Katherine Fritzges		Address 1037 Beechfield Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chn Myocarditis 422.1 DUE TO De compensation Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. DUE TO General Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Parkinson Syndrome, stroke		INTERVAL BETWEEN ONSET AND DEATH 6 mo 2 mo 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 19 61 to March 27, 1961 , that (I) (we) last saw the deceased alive on March 26, 1961 , and that death occurred at 4A M, from the causes and on the date stated above.			
22a. SIGNATURE B. Bruce Brumbaugh, M. D.		22b. DATE 3/28/61	
22c. PHYSICIAN'S NAME (Type) B. Bruce Brumbaugh, M. D.		22d. ADDRESS 5609 Main St. Elkridge 27, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DATE MAR 30 '61	
25b. REGISTRAR'S SIGNATURE C. Hubert S. Kraus			

0218

STATE OF CALIFORNIA

0218

San Francisco

San Francisco

San Francisco

1007 Second St. San Francisco

March 1, 1900

Dear Sir:

San Francisco

San Francisco

San Francisco 1007 Second St.

San Francisco

San Francisco

[Faint, mostly illegible handwritten text, possibly a list or ledger entries.]

San Francisco 1007 Second St.

San Francisco

San Francisco 1007 Second St.

San Francisco 1007 Second St.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2733

02714

1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>301-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Foxleigh Conv. Home</u>		d. STREET ADDRESS <u>5431 Price Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>SARA</u>		4. DATE OF DEATH <u>MARCH 14 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22 1901</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Julius Gaker - same</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN Tumor (glioblastoma)</u> DUE TO (b) <u>193.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<u>CORONARY artery disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>1955</u> to <u>MARCH 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>MARCH 7 1961</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Leonard Kotz</u>		22b. ADDRESS <u>6819- Reisterstown Rd Balto Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEONARD KOTZ, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3-15-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	23d. LOCATION (City or town or county) (State) <u>Balto Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc 3100 Eutan Pl</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 16 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

08314

08314

11

Butterfly

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1972

1
M
X
I
0
1
BP
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2734
2734
CERTIFICATE OF DEATH
02715

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. LENGTH OF STAY IN 1b Rockdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3512 Rolling Rd. Balto. 7				d. STREET ADDRESS 3512 Rolling Rd. Balto. 7			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mr. Charles Middle W. Last Garrison				4. DATE OF DEATH Month March Day 7 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 7, 1877	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Construction Foreman-C&P Tel.Co.				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Garrison				14. MOTHER'S MAIDEN NAME Phoebe Paul			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-0939		17. INFORMANT Mrs. Evelyn M. Garrison, 3512 Rolling Rd. Balto. 7.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X Congestive Heart Failure DUE TO (b) Bundled Asthma - Emphysema DUE TO (c) 10 Years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 10 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT 7, 1954 to March 7 19 61 , that (I) (we) last saw the deceased alive on March 6, 1961 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Edwin Pierpont				22b. DATE SIGNED 3/7/61			
22c. PHYSICIAN'S NAME (Type) Dr. Edwin Pierpont				22d. ADDRESS 8204 Liberty Rd. Baltimore 7, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-1961		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Long Byers				25a. REC'D BY REGISTRAR 8728 Liberty Road Randallstown, Md.		25b. REGISTRAR'S SIGNATURE Charles L. House	

UNITED STATES DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF VITAL RECORDS
WASHINGTON, D. C. 20540
CERTIFICATE OF DEATH

1950

1950



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G282 3-14-61 et

CERTIFICATE OF DEATH

2735

Reg. Dist. No.

02716

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>2101-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 29</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shady Nook Home</u>		d. STREET ADDRESS <u>2924 Strickland St.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Getz</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/24/1888</u>
9. AGE (In years last birthday) yrs. <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motorman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO TRANSIT CO</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Getz</u>		14. MOTHER'S MAIDEN NAME <u>MARY DELSCHER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. ALLEN W. GETZ ELLIOTT Md.</u>	
17. INFORMANT <u>Mrs. ALLEN W. GETZ ELLIOTT Md.</u>		Address <u>BALTO, NAT. PIKE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1930</u> to <u>3/4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/4</u> , 19 <u>61</u> , and that death occurred at <u>8:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Danman Pilgric</u> M.D. <u>3326 Frederick Ave</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/6/1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schwab Frederick Ave.</u>		ADDRESS <u>3512</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 6 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Robert S. Thomas</u>	

CERTIFICATE OF DEATH

1955

Page One of Two

03310

1. Name of Deceased		2. Sex		3. Race		4. Date of Birth		5. Date of Death		6. Place of Birth		7. Usual Residence		8. Cause of Death		9. Manner of Death		10. Signature of Physician		11. Signature of Registrar		12. Date of Registration	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2736

02717

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b <u>14 yrs 1m 25d.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>3009 DAR HILL AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ERNEST GIBBONS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1961</u>		5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>SEPT. 4, 1916</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE AGENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FRANK GIBBONS</u> 14. MOTHER'S MAIDEN NAME <u>MAUDE MARINER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> 16. SOCIAL SECURITY NO. <u>214-20-3476</u>		17. INFORMANT <u>RECORDS: SPRING GROVE STATE HOSP.</u> Address <u> </u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>March 7, 1961</u> to <u>March 17, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 17, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Jose R. Arizaga</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA, M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>			
23d. LOCATION (City, town or county) <u>Somerset Co., Md.</u> (State) <u> </u>		24 FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley, Glen</u> ADDRESS <u>Barnie, Md.</u>					
25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

52950

3659

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02718

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boring</i>		c. LENGTH OF STAY IN 1b <i>2.5 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>JOVA - E - GILL</i>		4. DATE OF DEATH <i>March 16 1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 25-1894</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>hair</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Riegley</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Myers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>M</i>	
17. INFORMANT <i>C Ross Gill, Boring Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma - lung - left</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>January 17, 1961</i> to <i>March 16, 1961</i> , that I last saw the deceased alive on <i>March 15, 1961</i> , and that death occurred at <i>1:35 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clarence E. McWilliams</i>		ADDRESS (Street, city or town, state) <i>11904 Chestnut Ave, Chestnut Hill, Md</i>	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED <i>March 16, 1961</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>3-19-1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Balto Co Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin Lipton</i>		ADDRESS <i>Wilmington Md</i>	
24a. REC'D BY REGISTRAR <i>MAR 20 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2559

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02719

2738 Item 1 c, Film G284 4/4/61 ink		Reg. Dist. No. 02719	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 207 Margaret Avenue Zone 21		d. STREET ADDRESS 207 MARGARET AVE, #21.	
3. NAME OF DECEASED (Type or print) Lillian First Middle Last GRAYSON		4. DATE OF DEATH 3 25 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 24, 1894
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH S. HOLSTON	
14. MOTHER'S MAIDEN NAME EMILY ?		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 215-16-5450		17. INFORMANT BERTHA E. COOK Address 3306 MUELLER ST. BALTO., 24, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) S.M.I. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JACK COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-29-61.	
22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEM.		22d. LOCATION (City, town, or county) 7225 EASTERN BLVD. BALTO., CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler ADDRESS 901 S. CONKLING ST. BALTO., 24, MD.		24a. REC'D BY REGISTRAR MAR 27 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO DEPARTMENT OF HEALTH
FOR STATE HEALTH DEPT.
1
If delay is necessary, file with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.
VS. A15ME
5M 7/59

Item 18 Filed 283 3-27-61														
MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
2739 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02720														
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's P. Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 4813 Trenton Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First JAMES Middle A. Last GREENWELL					4. DATE OF DEATH Month March Day 10 Year 19 61									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 12, 1928		9. AGE (In years last birthday) 32 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME John Joseph Greenwell					14. MOTHER'S MAIDEN NAME Grace Elizabeth Higgs									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address Mrs Ralph E. Stanton 507 Essex Dr. Lexington Pk.,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.0 Acute & Chronic Alcoholism DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/11/61									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 3/13/61		22c. NAME OF CEMETERY OR CREMATORY St. John's			22d. LOCATION (City, town, or country) (State) Hollywood, Md.						
23. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Maryland					24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns							

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10



U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10

U.S.S. 10



U.S.S. 10

U.S.S. 10

U.S.S. 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2740 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02721

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>6 MO -</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7525 LAWRENCE RD</u>				d. STREET ADDRESS <u>7525 LAWRENCE RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES W. GRETH</u>				4. DATE OF DEATH Month Day Year <u>MARCH 7 19 61</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR-15-1885</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MILLARD F. DEACON</u>				14. MOTHER'S MAIDEN NAME <u>DONT KNOW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>EUGENE H. GRETH 7525 LAWRENCE RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V - Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>ONE</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M. B. Davis</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS - M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>3/8/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHALMERS</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM F. FURBER</u>				ADDRESS <u>HOME DUNDALK</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2741 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										02722	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 683 S. Avondale Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILFORD GRIFFIN						4. DATE OF DEATH March 5, 1961					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-2-1914		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman				10b. KIND OF BUSINESS OR INDUSTRY Cab Co.				11. BIRTHPLACE (State or foreign country) Petersburg, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JUNIUS GRIFFIN						14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO						16. SOCIAL SECURITY NO. INFORMANT					
17. INFORMANT Mrs Shirley Griffin 683 S. Avondale St.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium 451X DUE TO ruptured aorta due to idiopathic medianecrosis of aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) aorta DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Russell S. Fisher M.D.						CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-61		22c. NAME OF CEMETERY OR CREMATORY McCalvary Cemetery		22d. LOCATION (City, town, or country) (State) Anne Arundel Co. Md.					
23. FUNERAL DIRECTOR Randolph J. Collick 1412 E. Preston St.						24a. REC'D BY REGISTRAR MAR 7 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

02328



655 E. Avenue Street

655 E. Avenue Street

1914

Michigan State Police Department

to be

State

Investigative Bureau

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2742
 02723
 Item 1 C, Film G283 3/24/61 jwk
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>P. G.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STRING GROVE HOSP. 2 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4730 HOMER AVE 1620-</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATONSVILLE MD.</u>				d. STREET ADDRESS <u>SUITLAND, MD.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD S. GROBAKER</u>				4. DATE OF DEATH Month Day Year <u>MARCH 17 1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/13/65</u>	9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RET.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VALENTINE GROBAKER</u>				14. MOTHER'S MAIDEN NAME <u>FRANCE FIELD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>CALVIN S. GROBAKER</u>		Address <u>SON</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY ARTERY DISEASE</u> 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>MAR 15 1961</u> to <u>MAR 17 1961</u> , that (I) (we) last saw the deceased alive on <u>MAR 17 1961</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Patrick K. Yip</u>				22b. DATE SIGNED <u>3/18/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>PATRICK K. YIP</u>				22d. ADDRESS <u>% SPRING GROVE STATE HOSPITAL BALTO. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3/21/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE</u>	23d. LOCATION (City, town or county) (State) <u>BALTO. CO. MD.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don - 28</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

03733

I

CORRECTIONAL INSTITUTION

PATRICK K. YIP
MAR 17 1961

MAR 18 1961

2 years (state prison)

MAR 18 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
2743									
02724									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard					c. LENGTH OF STAY IN 1b 20 days				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 1100 E. Hoffman Street				
3. NAME OF DECEASED (Type or print) HUGO					4. DATE OF DEATH March 12 1961				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> GRUHN					8. DATE OF BIRTH 10/21/89				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman					10b. KIND OF BUSINESS OR INDUSTRY Bakery				
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frederick Gruhn					14. MOTHER'S MAIDEN NAME Whilamenia Winkleman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. WW-1 220-01-4385				
17. INFORMANT Clinical Records, VA Hospital DIV.					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA WITH BRONCHOPLEURAL FISTULA, RT.					INTERVAL BETWEEN ONSET AND DEATH 25 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X					(b) EMPHYEMA, RIGHT PLEURAL SPACE				
					(c) HYPERTROPHY AND DILATATION OF THE HEART				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that 10 (this hospital) attended the deceased from Feb. 20, 1961 to Mar. 12, 1961 , that 10 (we) last saw the deceased alive on March 12, 1961 , and that death occurred at 4:40 P.M. from the causes and on the date stated above.									
22a. SIGNATURE John D. Talbert, M.D.					22b. DATE SIGNED 3/12/61				
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D.					22d. ADDRESS VAH, 3900 Loch Raven Blvd. Baltimore 18, Maryland-FORT HOWARD DIVISION				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 3-15-61				
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery					23d. LOCATION (City, town or county) (State) Baltimore Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.					25a. REC'D BY REGISTRAR 6009 Harford Road Baltimore, Md.				
					25b. REGISTRAR'S SIGNATURE Charles E. Hines				
					DATE MAR 15 '61				

29125

2801-45-255

10-21-61

McCook-Lindsay, Inc.

Page 10

• *See also* 100-101, 102-103, 104-105, 106-107, 108-109, 110-111, 112-113, 114-115, 116-117, 118-119, 120-121, 122-123, 124-125, 126-127, 128-129, 130-131, 132-133, 134-135, 136-137, 138-139, 140-141, 142-143, 144-145, 146-147, 148-149, 150-151, 152-153, 154-155, 156-157, 158-159, 160-161, 162-163, 164-165, 166-167, 168-169, 170-171, 172-173, 174-175, 176-177, 178-179, 180-181, 182-183, 184-185, 186-187, 188-189, 190-191, 192-193, 194-195, 196-197, 198-199, 200-201, 202-203, 204-205, 206-207, 208-209, 210-211, 212-213, 214-215, 216-217, 218-219, 220-221, 222-223, 224-225, 226-227, 228-229, 230-231, 232-233, 234-235, 236-237, 238-239, 240-241, 242-243, 244-245, 246-247, 248-249, 250-251, 252-253, 254-255, 256-257, 258-259, 260-261, 262-263, 264-265, 266-267, 268-269, 270-271, 272-273, 274-275, 276-277, 278-279, 280-281, 282-283, 284-285, 286-287, 288-289, 290-291, 292-293, 294-295, 296-297, 298-299, 300-301, 302-303, 304-305, 306-307, 308-309, 310-311, 312-313, 314-315, 316-317, 318-319, 320-321, 322-323, 324-325, 326-327, 328-329, 330-331, 332-333, 334-335, 336-337, 338-339, 340-341, 342-343, 344-345, 346-347, 348-349, 350-351, 352-353, 354-355, 356-357, 358-359, 360-361, 362-363, 364-365, 366-367, 368-369, 370-371, 372-373, 374-375, 376-377, 378-379, 380-381, 382-383, 384-385, 386-387, 388-389, 390-391, 392-393, 394-395, 396-397, 398-399, 400-401, 402-403, 404-405, 406-407, 408-409, 410-411, 412-413, 414-415, 416-417, 418-419, 420-421, 422-423, 424-425, 426-427, 428-429, 430-431, 432-433, 434-435, 436-437, 438-439, 440-441, 442-443, 444-445, 446-447, 448-449, 450-451, 452-453, 454-455, 456-457, 458-459, 460-461, 462-463, 464-465, 466-467, 468-469, 470-471, 472-473, 474-475, 476-477, 478-479, 480-481, 482-483, 484-485, 486-487, 488-489, 490-491, 492-493, 494-495, 496-497, 498-499, 500-501, 502-503, 504-505, 506-507, 508-509, 510-511, 512-513, 514-515, 516-517, 518-519, 520-521, 522-523, 524-525, 526-527, 528-529, 530-531, 532-533, 534-535, 536-537, 538-539, 540-541, 542-543, 544-545, 546-547, 548-549, 550-551, 552-553, 554-555, 556-557, 558-559, 560-561, 562-563, 564-565, 566-567, 568-569, 570-571, 572-573, 574-575, 576-577, 578-579, 580-581, 582-583, 584-585, 586-587, 588-589, 590-591, 592-593, 594-595, 596-597, 598-599, 600-601, 602-603, 604-605, 606-607, 608-609, 610-611, 612-613, 614-615, 616-617, 618-619, 620-621, 622-623, 624-625, 626-627, 628-629, 630-631, 632-633, 634-635, 636-637, 638-639, 640-641, 642-643, 644-645, 646-647, 648-649, 650-651, 652-653, 654-655, 656-657, 658-659, 660-661, 662-663, 664-665, 666-667, 668-669, 670-671, 672-673, 674-675, 676-677, 678-679, 680-681, 682-683, 684-685, 686-687, 688-689, 690-691, 692-693, 694-695, 696-697, 698-699, 700-701, 702-703, 704-705, 706-707, 708-709, 710-711, 712-713, 714-715, 716-717, 718-719, 720-721, 722-723, 724-725, 726-727, 728-729, 730-731, 732-733, 734-735, 736-737, 738-739, 740-741, 742-743, 744-745, 746-747, 748-749, 750-751, 752-753, 754-755, 756-757, 758-759, 760-761, 762-763, 764-765, 766-767, 768-769, 770-771, 772-773, 774-775, 776-777, 778-779, 780-781, 782-783, 784-785, 786-787, 788-789, 790-791, 792-793, 794-795, 796-797, 798-799, 800-801, 802-803, 804-805, 806-807, 808-809, 810-811, 812-813, 814-815, 816-817, 818-819, 820-821, 822-823, 824-825, 826-827, 828-829, 830-831, 832-833, 834-835, 836-837, 838-839, 840-841, 842-843, 844-845, 846-847, 848-849, 850-851, 852-853, 854-855, 856-857, 858-859, 860-861, 862-863, 864-865, 866-867, 868-869, 870-871, 872-873, 874-875, 876-877, 878-879, 880-881, 882-883, 884-885, 886-887, 888-889, 890-891, 892-893, 894-895, 896-897, 898-899, 900-901, 902-903, 904-905, 906-907, 908-909, 910-911, 912-913, 914-915, 916-917, 918-919, 920-921, 922-923, 924-925, 926-927, 928-929, 930-931, 932-933, 934-935, 936-937, 938-939, 940-941, 942-943, 944-945, 946-947, 948-949, 950-951, 952-953, 954-955, 956-957, 958-959, 960-961, 962-963, 964-965, 966-967, 968-969, 970-971, 972-973, 974-975, 976-977, 978-979, 980-981, 982-983, 984-985, 986-987, 988-989, 990-991, 992-993, 994-995, 996-997, 998-999, 1000-1001, 1002-1003, 1004-1005, 1

1
M
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2744
CERTIFICATE OF DEATH
02725

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 6 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School		d. STREET ADDRESS 722 West Washington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Randy Lynn Guessford		4. DATE OF DEATH 3 15 19 61		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/22/58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none		9. AGE (In years last birthday) 2 yrs.	
13. FATHER'S NAME Robert Lee Guessford		14. MOTHER'S MAIDEN NAME Ester Rochell Hawkins		11. BIRTHPLACE (County & State, or foreign country) Washington Co., Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Bronchopneumonia and otitis media complicating brain DUE TO (c) Damage		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at 5:55 p.m. on....., the causes and on the date stated above.					
22a. SIGNATURE D. W. Rieckert		22b. DATE 3-16-61		22c. PHYSICIAN'S NAME (Type) D. W. Rieckert	
22d. ADDRESS 4307 Mainfield Ave		22e. REC'D BY REGISTRAR MAR 21 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Kinn	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-18-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Garden	
23d. LOCATION (City, town or county) Hagerstown		23e. (State) Md		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Mennich		24a. ADDRESS Hagerstown, Md.		24b. DATE MAR 21 '61	

05780

2744

M

1

Handwritten text, possibly a signature or name, appearing upside down.

John W. Rickert
1507 Monmouth St
Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02726

2745

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 19 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11 Midway Avenue		e. STREET ADDRESS 11 Midway Avenue	
3. NAME OF DECEASED (Type or print) First IDA Middle +++ Last HALE		4. DATE OF DEATH Month March Day 16th Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 29, 1866
9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR: Months 1 Days 2 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Sweeden		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Emberg		14. MOTHER'S MAIDEN NAME Hannah (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Edna Gochnour		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Serility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Serility DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 52 to March , 19 60 , that I last saw the deceased alive on 3-16- 19 61 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2900 Dunran Road DATE SIGNED 3/18/61			
ACTUAL SIGNATURE B.W. Solled		PHYSICIAN'S NAME (Type) B.W. Solled, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/61	
22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Memorial		22d. LOCATION (City, town, or county) (State) Johnstown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2746

CERTIFICATE OF DEATH

02727

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainesville		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1805 E. Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle Bernard Last Hamson		4. DATE OF DEATH Month March Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1878
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone mason (repairing for Mill Co.)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Hill Hamson		14. MOTHER'S MAIDEN NAME Barbara Louise Stepler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-6171A	
17. INFORMANT Mr. Norman T. Hamson		Address Catonsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Generalized + Coronary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs, 20 yrs,	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 6, 1961 , to March 6, 1961 , that (I) (we) last saw the deceased alive on March 6, 1961 , and that death occurred at 7 AM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph F. LiPira M.D.		22b. DATE SIGNED 3/7/61	
22c. PHYSICIAN'S NAME (Type) Joseph F. LiPira M. D.		22d. ADDRESS 8400 Loch Haven Blvd. Beltsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/1961	
23c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery		23d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Eastern Funeral Home		25a. REC'D BY REGISTRAR MAR 8 '61	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2747

02728

1. PLACE OF DEATH e. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr26dys	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air, Maryland	
3. NAME OF DECEASED (Type or print) First John Middle Martin Last Handy, Sr.		d. STREET ADDRESS Box 313 - Route #2	
5. SEX male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 2, 1877	
9. AGE (In years last birthday) 88ys.		10. IF UNDER 1 YEAR Months 8 Days 2	
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Handy		14. MOTHER'S MAIDEN NAME Melissa Margaret Reeves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-32-3741	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C. V. A. (Cerebral Hemorrhage)			
DUE TO (b) Arteriosclerotic Aortic Valvular Stenosis			
DUE TO (c) Arteriosclerotic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
Chronic Brain Syndrome associated with Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Feb. 24, 1961 to 3-4, 1961 that (I) (we) last saw the deceased alive on March 4, 1961 and that death occurred at 8:45 pm from the causes and on the date stated above.			
22a. SIGNATURE Jose R. Arizaga M.D.			
22b. DATE SIGNED March 5, 1961			
22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA			
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Mar. 8, 1961			
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion			
23d. LOCATION (City, town or county) (State) Bel Air Harford Md.,			
24. FUNERAL DIRECTOR'S SIGNATURE Howard M. Conner			
ADDRESS Abingdon, Md.			
25a. REC'D BY REGISTRAR MAR 10 '61			
25b. REGISTRAR'S SIGNATURE William S. Thomas			

VR A15 (4)
15M 9/60

0838

3542

115

10

4

Mr.

Mr. J. H. Martin

Mr. J. H. Martin

Mr. J. H. Martin

...

Received from Mr. J. H. Martin

210-38-1741

1

MA

801 Air Station

Mr. J. H. Martin

Mar. 6, 1961

Barling

Barling, Mar. 6, 1961

1
M
059
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2748

02729

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN lb 3 Days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			d. STREET ADDRESS Route 3, Box 123		
3. NAME OF DECEASED (Type or print) First Middle Last PERRY F. HANDY			4. DATE OF DEATH Month Day Year March 23 19 61		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 11, 1891		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Queen Annes County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Handy			14. MOTHER'S MAIDEN NAME Mary Gould		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 213-24-4813	17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXIII (b) DUE TO HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE (c) UREMIA DUE TO (b)					INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Centreville, Maryland	(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 20 1961 to March 23 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 23 1961 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Thomas F. Crahan			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/24/61
22c. PHYSICIAN'S NAME THOMAS F. CRAHAN, M.D.			22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/61	23c. NAME OF CEMETERY OR CREMATORY Gouldtown	23d. LOCATION (City, town or county) (State) Centreville, Maryland RFD		
24. FUNERAL DIRECTOR'S SIGNATURE James B. Ashwell, Eastern, Md			25a. REC'D BY REGISTRAR DATE MAR 29 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

08080

2723



Handwritten

Handwritten

Constitution

1 Day

1 Day

Box 2, Box 123

Handwritten

HARDY

Handwritten

December 11, 1941

Colonel

Main

Green Anna County, Md. U. S. A.

Handwritten

Mary Gould

Handwritten

Handwritten

Handwritten

BROCHURE

DUE TO EXHAUSTIVE CARDIOVASCULAR AND LUNG DISEASE

Handwritten

QUESTA FOR TO (P)

March 20, 1941

March 20, 1941

3/24/41

Handwritten

Handwritten

Handwritten

Handwritten

Handwritten

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

2749

02730

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4228 Belmar Avenue (6) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HAROLD A. HARRISON				4. DATE OF DEATH Month March Day 23 Year 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 24, 1893	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY Houses - Boats		11. BIRTHPLACE (County & State, or foreign country) Tilghman, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY Houses - Boats		11. BIRTHPLACE (County & State, or foreign country) Tilghman, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac A. Harrison				14. MOTHER'S MAIDEN NAME Sarah E. Lowery			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 218-09-0006		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO (b) RECURRENT ADENOCARCINOMA, COLON DUE TO (c) FECAL FISTULA, Due to (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? EMACIATION Duration Unknown- Due to Recurrent Adenocarcinoma (b) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) March 20, 1961, March 23, 1961	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 23, 1961 to March 23, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 23, 1961 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F. Crahan</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/23/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Tilghman's Meth. Church Cem.		23d. LOCATION (City, town or county) (State) Tilghman's Island, Talbot Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home, 7401 Belair Rd. Balto., Md.				25a. REC'D BY REGISTRAR MAR 27 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

03130

03130

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

U. S. A.

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

Washington

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2750
CERTIFICATE OF DEATH
02731

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 4 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1101 Flamingo Dr.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clementine Middle Heckathorn Last		4. DATE OF DEATH Month March Day 10 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hosewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Amos James Gregory		14. MOTHER'S MAIDEN NAME Celeste Nunnelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Amos J. Heckthorn		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 153.8 (c) 153.8 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 153.8		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Feb Day 12 Year 1961 Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 12, 1961 to 3-10, 1961 , that (I) was last saw the deceased alive on Feb 12, 1961 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Earl Pass		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Earl I. Pass		22d. ADDRESS 4001 Wilkens Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/17/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park cem.		23d. LOCATION (City, town, or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Ambrose		25a. REC'D BY REGISTRAR DATE MAR 13 '61	
ADDRESS 1328 Sulphur Spring Rd. Balt. 27, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

02334

CERTIFICATE OF DEATH

3750

Residence

Married

Age

3750

Religion

Sex

Religion

1201 Williams Ave.

1201 Williams Ave.

Married

Married

June 12, 1950

June 12, 1950

U.S.A.

U.S.A.

George Kennedy

James Gregory

James J. Kennedy

James J. Kennedy

1201 Williams Ave.

1201 Williams Ave.

Mo.

Religion

Married

Married

Married

1201 Williams Ave.

1201 Williams Ave.

may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02732

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House of Pines		d. STREET ADDRESS 4910 Palmer Ave.	
3. NAME OF DECEASED (Type or print) LENA HECKLEMAN		4. DATE OF DEATH Month 3 Day 16 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 16 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abe Cohen		14. MOTHER'S MAIDEN NAME Minnie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mrs Lillian Klein ---- Same	
17. INFORMANT Mrs Lillian Klein		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertension, Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 15 yrs.			INTERVAL BETWEEN ONSET AND DEATH 1 day
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8-25-1959 to 3-16-1961 , that (I) (we) last saw the deceased alive on 3-16-1961 , and that death occurred at 2043 M , from the causes and on the date stated above.			
22a. SIGNATURE William K. Gallagher		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William K. Gallagher		22d. ADDRESS 6209 Frederick Ave, Balt 28, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/17/61	23c. NAME OF CEMETERY OR CREMATORY Beth Hamedrosh Hagodol	23d. LOCATION (City, town, or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC.		25a. REC'D BY REGISTRAR MAR 20 '61	
ADDRESS 6010 Reisterstown Rd.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1
\$
(M)

(I)

1
ap

0228

CERTIFICATE OF DEATH

2288

(M)

DEPARTMENT OF HEALTH
Baltimore, Maryland
Date of Death: _____
Place of Death: _____
Cause of Death: _____
Age: _____
Sex: _____
Race: _____
Occupation: _____
Signature: _____
Registrar: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2252

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02733

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cherry Hill Lane</u>				d. STREET ADDRESS <u>Cherry Hill Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emory A. Heiges</u>				4. DATE OF DEATH Month Day Year <u>March 19, 19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Heiges</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Arnsberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>160-16-9838</u>		17. INFORMANT Address <u>Mrs. Anna Bohrer Bigleville, Penna.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic C-V Disease</u> (c) <u>Arteriosclerotic C-V Disease</u> DUE TO cote the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>none 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 22, 61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arendtsville Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>				ADDRESS <u>Reisterstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

DATE SIGNED

3-20-61

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

92788

14

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		10-10-51	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		LOCALITY	
HOME		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		BALTIMORE, MD	
HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESS		HISTORY OF SURGERY		HISTORY OF DRUGS		HISTORY OF ALCOHOL	
Patient was ill for several days with chest pain and shortness of breath.		Patient had no previous illness.		Patient had no surgery.		Patient was on no drugs.		Patient had no alcohol.	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		RADIOLOGIC EXAMINATIONS		HISTOPATHOLOGIC EXAMINATIONS		TOXICOLOGIC EXAMINATIONS	
Chest examination showed clear lungs and normal heart sounds.		No laboratory examinations were performed.		No radiologic examinations were performed.		No histopathologic examinations were performed.		No toxicologic examinations were performed.	
GROSS EXAMINATION		MICROSCOPIC EXAMINATION		HISTOCHEMICAL EXAMINATION		IMMUNOHISTOCHEMICAL EXAMINATION		CYTOLOGIC EXAMINATION	
Autopsy was performed and showed normal findings.		Microscopic examination showed normal findings.		No histochemical examinations were performed.		No immunohistochemical examinations were performed.		No cytologic examinations were performed.	
FINDINGS		CONCLUSIONS		REMARKS		SIGNATURE OF EXAMINER		DATE	
The cause of death was heart disease.		The manner of death was natural.		The disease or injury was coronary artery disease.		J. H. Harris, M.D.		10-10-51	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2753

CERTIFICATE OF DEATH

02734

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN lb <u>1</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>2919 Church Road</u>	
3. NAME OF DECEASED (Type or print) <u>Johanna Heinlein</u> First Middle Last		4. DATE OF DEATH <u>3 14 19 61</u> Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-1863</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME (First name) <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Katherine (nee-Unknown)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Straulau</u>		17. INFORMANT <u>Mrs Madelon Welsh</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatoid arthritis</u> DUE TO (c) <u>destruction of the sigmoid</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs</u> <u>4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>March 25</u>, 19<u>61</u> to <u>March 14</u>, 19<u>61</u>; that (I) (we) last saw the deceased alive on <u>March 14</u>, 19<u>61</u>, and that death occurred at <u>9:00 AM</u>, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Leonard J. Ruck</u>		22d. ADDRESS <u>5305 Harford Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3-17-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>MAR 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. **NEURAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it must be filed in the office of the Director of Health. It is then removed to the office of the Registrar of Births and Deaths for use as the burial permit. Then please remove carbon copy to the office of the Registrar of Births and Deaths.

within 24 hours after
filled in by the funeral

TO HO
death.
TO FU

VR A1E
15M 9/

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 23b, Film G283 3/20/61 iwk

02735

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BORT HOWARD c. LENGTH OF STAY IN 1b 10 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 612 W LEE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES First Middle Last HELLER		4. DATE OF DEATH MARCH 6 19 61 Month Day Year	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUGUST 20 1899 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESS OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY STANDARD STEEL	
11. BIRTHPLACE (County & State, or foreign country) COLUMBIA, SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ADAM HELLER		14. MOTHER'S MAIDEN NAME MAGGIE NELLAMS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO. CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION	
17. INFORMANT CLIN REC VAH BALTIMORE MD-FT HOWARD DIVISION		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. CEREBRAL VASCULAR THROMBOSIS DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 DAY 3 WEEKS 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LAENNEC'S CIRRHOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 24, 1961 to March 6, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 6, 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE William S. Kiser M.D.		22b. DATE SIGNED 3-6-61	
22c. PHYSICIAN'S NAME (Type) WILLIAM S. KISER M.D.		22d. ADDRESS VAH Baltimore, Md. - Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/10/61	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND
24 FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice Funeral Service Baltimore 30, Md		25a. REC'D BY REGISTRAR MAR 13 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

director, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05387

05387



WASHINGTON

BALTIMORE

BALTIMORE

10 DAYS

WEST VIRGINIA

612 W. 1st Street

WEST VIRGINIA AMBULANCE HOSPITAL

61

MARCH

REPAIR

JAMES

X AUGUST 20 1892

CONRAD

WIFE

U.S.A.

COLUMBIA, SOUTH CAROLINA

STANDARD STEEL

WASG OPERATOR

NACOLE LINDA

ADAM ELLER

(1)

COIN FRO VAN BALTIMORE TO THE WINDY DIVISION

W-11

YES

1 DAY

EXCHANGING

3 WEEKS

CENTRAL VASCULAR THROMBOSIS

10 YEARS

HYPERSENSITIVE CAPILLARY DISEASE

ARTERIAL CHROMOSIS

61

100. 24. 1:30

61

100. 24. 1:30

10-0-01

W. 1st Street, Baltimore, Md. - St. Howard Division

M.D.

WEST VIRGINIA

WASHINGTON

BALTIMORE

WEST VIRGINIA

BALTIMORE

Charles A. Rice Funeral Service Baltimore 30, Md.
100. 24. 1:30

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2355

Item 14 Film G285 4/17/61 mb

CERTIFICATE OF DEATH

Reg. Dist. No. 02736

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3205 Second Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES First Middle Last HESS		4. DATE OF DEATH March Month 19 , Day 19 , Year 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 2, 1871
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LITHOGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY Retired 30 Yrs Philadelphia, Penna.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME August Hess		14. MOTHER'S MAIDEN NAME Barbara Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Walter Wm. Sonn-3205 Second Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Hemiplegia left 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 24 hours 1939	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 8, 1950 , to March 19, 1961 , that I last saw the deceased alive on March 19, 1961 , and that death occurred at 11:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. J. Alessi		DATE SIGNED 3/20/61	
PHYSICIAN'S NAME (Type) E. J. Alessi; M.D.		ADDRESS (Street, city or town, state) 6217 Hartford Rd	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/22/61	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC. Balto., Md.		24a. REC'D BY REGISTRAR MAR 22 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

US330

CENTRAL OF DEATH

1943



13

1943

1943

13

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

1943

CERTIFICATE OF DEATH

02735

1. PLACE OF DEATH a. COUNTY 7829-Highpoint Rd CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) June 14 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X BALTIMORE d. STREET ADDRESS 17829-Highpoint-Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas OWENS, HOGAN First Middle Last 4. DATE OF DEATH MAR - 19 1961 Month Day Year		9. AGE (In years last birthday) 47 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB - 21 - 1914 10b. KIND OF BUSINESS OR INDUSTRY BENDIX 11. BIRTHPLACE (County & State, or foreign country) ROCHESTER, PA. 12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 13. FATHER'S NAME REDMAN, HOGAN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 187-01-1287		14. MOTHER'S MAIDEN NAME LUELLA - STEWART 17. INFORMANT Address BEATRICE JACOBS, 7829 Highpoint Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Carcinoma, right lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above			
22a. SIGNATURE James E. I. Hopkins 22c. PHYSICIAN'S NAME (Type) JAMES E. I. HOPKINS		22b. DATE SIGNED 22d. ADDRESS 205 W LANVALE ST BALTO MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3-22-61	
23c. NAME OF CEMETERY OR CREMATORY Doughterty Cem.		23d. LOCATION (City, town or county) (State) Rochester PA	
24. FUNERAL DIRECTOR'S SIGNATURE LEONARD J. RUCK ADDRESS 5305 Hartford Rd		25a. REC'D BY REGISTRAR DATE MAR 21 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

0273

0273

William Lloyd

(M)

June 14

(1)

James E. Hopkins, Secretary
of the American
League of Free Nations

1 FOR STATE HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2757

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02738

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>847 W. University Parkway</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Howard</u> Middle <u>Hollingshead</u> Last		4. DATE OF DEATH <u>March</u> Month <u>12</u> Day <u>1961</u> Year		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 23, 1882</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Roger Hollingshead</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN Eugenia Barton</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-07-5984</u>				17. INFORMANT Address <u>Mrs. Ellen R. Hollingshead-847 W. University Pk. Records: SPRING GROVE STATE HOSPITAL</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>General thrombosis (Central Aneurysm)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>X-ray of 3-2-61 revealed comminuted frac. of lateral end of left clavicle which pt. allegedly sustained in a fall at home.</u>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>?</u> p.m. <u>2-28 1961</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>				20f. (City or town) <u>Baltimore City</u> (State) <u>(State)</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>George M. Kieffer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>George M. Kieffer, M. D.</u>				Address (Street, city, town, or county) <u>1010 Leaden</u>				DATE SIGNED <u>3-13-61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR <u>Wm. J. Lickner & Sons</u>				ADDRESS <u>117 N. Ave</u>				24a. REC'D BY REGISTRAR <u>MAR 13 '61</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

8650

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02739**

1. PLACE OF DEATH a. COUNTY Baltimore <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Fairway Rd.				d. STREET ADDRESS 11 Fairway Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alfred Middle H Last HUDNET		4. DATE OF DEATH Month Mar. Day 15 Year 1961		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1907		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Surveyor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Augustus R Hudnut				14. MOTHER'S MAIDEN NAME Florence W Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Samuel S Hudnet 329 Taylor Ave. 21			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X Suicide - gunshot DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 second	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. Shot self in left chest with 12 gauge shotgun					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JACK COLLINS				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 18, 1961		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc. 1217 St. Paul St.				ADDRESS 1217 St. Paul St.		24a. REC'D BY REGISTRAR MAR 21 '61 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
2222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



NAME OF DECEASED (Print name in full)		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE (In years and months)		DATE OF BIRTH	
PLACE OF BIRTH		OCCUPATION	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		RACE	
CAUSE OF DEATH (State immediately apparent cause of death)		MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS	
DATE OF EXAMINATION		TIME OF EXAMINATION	
PLACE OF EXAMINATION		COUNTY	
CITY		STATE	
ZIP CODE		TELEPHONE	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF NEXT OF KIN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF NEXT OF KIN	
DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
X
I
2759
M
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02740

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>EUGENE HUNDERT MARK</u>		4. DATE OF DEATH <u>March 4</u> 19 <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27-1880</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Works</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hundertmark</u>		14. MOTHER'S MAIDEN NAME <u>Martha Boeing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Jacob Hundertmark</u>		Address <u>Reisterstown Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>none</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>none</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6-16-54</u> 19 <u>54</u> , to <u>3-4</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-2-61</u> 19 <u>61</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>D. D. Caples</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>D. D. CAPLES, M.D.</u>		22d. ADDRESS <u>6 Hanover Rd, Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-7-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Sipton</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
24a. ADDRESS <u>Hampstead Md</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 9 '61</u>	

04554

1990

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2760

02742

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 48yr8mth14dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS UNKNOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lottie		First Lottie		Middle Hyder		Last Hyder	
4. DATE OF DEATH Month March		Day 22		Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1884?	
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months 76		IF UNDER 24 HRS. Days 76		Hours 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) SPRING GROVE STATE HOSPITAL		(County) Baltimore		(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1957 to March 22, 1961 , that (I) (we) last saw the deceased alive on March 2, 1961 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 3-23-61		22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		23a. REC'D BY REGISTRAR DATE MAR 27 '61		23b. REGISTRAR'S SIGNATURE Carlton S. Kline		23c. NAME OF CEMETERY OR CREMATORY Goodell Frederick	
23d. LOCATION (City, town, or county) Baltimore		(State) Maryland		23e. DATE THEREOF 3/25/61		23f. NAME OF CEMETERY OR CREMATORY Goodell Frederick	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Johnson		ADDRESS 1318 Light		25a. REC'D BY REGISTRAR DATE MAR 27 '61		25b. REGISTRAR'S SIGNATURE Carlton S. Kline	

5559

1985

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2761

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02743

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4yr 5mthldy</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>J.</u> Last <u>Imbrogulio</u>		4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1899</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fuel oil distributor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>fuel oil bus.</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u> ✓	
13. FATHER'S NAME <u>Samuel Imbrogulio</u>		14. MOTHER'S MAIDEN NAME <u>Concetti Magio</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W. W. I.</u>		16. SOCIAL SECURITY NO. <u>215-03-0403</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 16, 1960</u> to <u>March 7, 1961</u> that (I) (we) last saw the deceased alive on <u>March 7, 1961</u> and that death occurred at <u>3:20</u> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler</u>		22b. DATE SIGNED <u>3-7-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3-10-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		23d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schwegel</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 8 '61</u>	
ADDRESS <u>Phonics or Midway 2101 Federal Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

02751

CERTIFICATE OF DEATH

1971

11

1

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10-10-2001 BY 60320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2762

CERTIFICATE OF DEATH

Items 13 & 14 Film G282 3/16/61 mh

02744

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3040 Fourth Ave.</u>		d. STREET ADDRESS <u>3040 Third Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph Lawrence Jackson</u>		4. DATE OF DEATH <u>3 10 19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		17. INFORMANT <u>J. Lawrence Jackson</u> Address <u>3040 4th Ave. Carney</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular disease</u> (a), stating the underlying cause last. (c) <u>Vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia of Old Cerebrovascular Thrombosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part f of Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>Nov 1961</u> , the (I) (we) last saw the deceased alive on <u>3/2</u> 19 <u>61</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank T. Kasik Jr</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>FRANK T KASIK</u>		22d. ADDRESS <u>9005 HARFORD RD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3/13/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. PK</u>	23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>MAR 13 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>			

2275

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2763
CERTIFICATE OF DEATH
02745

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cresco Acres</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>40 Left Wing Bldg</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FLORENCE</i> First Middle Last <i>L. JACOB</i>		4. DATE OF DEATH <i>Mar. 27</i> Month Day Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 10-1890</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		12. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
13. FATHER'S NAME <i>August Gerber</i>		14. MOTHER'S MAIDEN NAME <i>Subrina Fields</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Husband</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Carcinomatosis</i> (c) <i>Carcinoma of Breast</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 yrs</i> <i>5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1</i> 19 <i>61</i> , to <i>March 27</i> 19 <i>61</i> , that (I) (we) lost saw the deceased alive on <i>March 27</i> 19 <i>61</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>JMB Armgardner</i> M.D.		22b. DATE SIGNED <i>3/29/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Balto 6 Md</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3-30-1961</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Balto Natl Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connolly</i>		25. DEC'D BY REGISTRAR <i>APR 3 '61</i>	
ADDRESS <i>418 Eastern Blvd 21, Md</i>		25b. REGISTRAR'S SIGNATURE <i>William S. Kraus</i>	

0538

3763

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

Arthur L. Foss

VR A15 (4)
15M 9/60

14550

2765

CERTIFICATE OF DEATH

Reg. Dist. No. 02747

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>4 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1818 Weyburn Rd</u>		d. STREET ADDRESS <u>3205 BATHURIA AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTHER ESTELLA JANSEN</u>		4. DATE OF DEATH Month Day Year <u>MARCH 5 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5 1907</u> 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MILLER</u>		14. MOTHER'S MAIDEN NAME <u>LOHIA WEITZEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ALFRED H. JANSSEN</u>		Address <u>3205 BATHURIA AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO <u>153.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA, GENERALIZED</u> DUE TO <u>CARCINOMA, SIGMOID COLON</u> (c) <u>5 YRS.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>AUG. 1956</u> to <u>MARCH 1961</u> , that I last saw the deceased alive on <u>MAR. 2 1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 W. MADISON ST. BALTO. 1 MD.</u> DATE SIGNED <u>James P. O'Hare</u> M.D.			
ACTUAL SIGNATURE <u>James P. O'Hare</u>		PHYSICIAN'S NAME (Type) <u>BALTO. 1 MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-8-1961</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James P. O'Hare</u>		ADDRESS <u>5305 Bayford</u>	
24a. REC'D BY REGISTRAR <u>MAR 7 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3185

1871

1871

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. PLACE OF DEATH	
JAMES H. HARRIS		Male		45		1871		At Home	
6. OCCUPATION		7. CAUSE OF DEATH		8. MEDICAL HISTORY		9. PRESENT ILLNESS		10. TIME OF DEATH	
None		Heart Disease		None		Heart Disease		10:00 AM	
11. PLACE OF BIRTH		12. DATE OF BIRTH		13. PLACE OF BIRTH		14. DATE OF BIRTH		15. PLACE OF BIRTH	
Maryland		1826		Maryland		1826		Maryland	
16. NAME OF PHYSICIAN		17. NAME OF SURGEON		18. NAME OF MINISTER		19. NAME OF CLERGYMAN		20. NAME OF FUNERAL	
Dr. J. H. Harris		None		None		None		None	
21. NAME OF FUNERAL HOME		22. NAME OF FUNERAL HOME		23. NAME OF FUNERAL HOME		24. NAME OF FUNERAL HOME		25. NAME OF FUNERAL HOME	
None		None		None		None		None	
26. NAME OF FUNERAL HOME		27. NAME OF FUNERAL HOME		28. NAME OF FUNERAL HOME		29. NAME OF FUNERAL HOME		30. NAME OF FUNERAL HOME	
None		None		None		None		None	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. PLACE OF DEATH
6. OCCUPATION
7. CAUSE OF DEATH
8. MEDICAL HISTORY
9. PRESENT ILLNESS
10. TIME OF DEATH
11. PLACE OF BIRTH
12. DATE OF BIRTH
13. PLACE OF BIRTH
14. DATE OF BIRTH
15. PLACE OF BIRTH
16. NAME OF PHYSICIAN
17. NAME OF SURGEON
18. NAME OF MINISTER
19. NAME OF CLERGYMAN
20. NAME OF FUNERAL
21. NAME OF FUNERAL HOME
22. NAME OF FUNERAL HOME
23. NAME OF FUNERAL HOME
24. NAME OF FUNERAL HOME
25. NAME OF FUNERAL HOME
26. NAME OF FUNERAL HOME
27. NAME OF FUNERAL HOME
28. NAME OF FUNERAL HOME
29. NAME OF FUNERAL HOME
30. NAME OF FUNERAL HOME

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2766

CERTIFICATE OF DEATH

Reg. Dist. No.

02748

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keistastown</u>		c. LENGTH OF STAY IN 1b <u>82 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>(C)</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1878</u>
9. AGE (In years last birthday) <u>82 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer, general</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Hane Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-308</u>	
17. INFORMANT <u>Rudolf A. Madden</u>		Address <u>2571 Madison St. Port.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Vascular Cerebral Nec</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HASCD</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>30 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>60</u> , to <u>Mar 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 10</u> , 19 <u>61</u> , and that death occurred at <u>6:17</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin J. Feldmann</u>		ADDRESS (Street, city or town, state) <u>#1 Chary Hill Rd Keistastown MD</u>	
PHYSICIAN'S NAME (Type) <u>Martin J. Feldmann</u>		DATE SIGNED <u>3/1/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>March 4</u>		22b. DATE THEREOF <u>March 4</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Lukes Cemetery Keistastown MD</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaac Johnson</u>		ADDRESS <u>2313 Hill Ave</u>	
24a. REC'D BY REGISTRAR <u>Charles E. King</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. King</u>	
DATE <u>MAR 1 '61</u>			

02764

Page 2 of 2

CERTIFICATE OF DEATH

3358

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male/Female]</p>	
<p>3. DATE OF BIRTH [Date of birth]</p>		<p>4. PLACE OF BIRTH [Place of birth]</p>	
<p>5. DATE OF DEATH [Date of death]</p>		<p>6. PLACE OF DEATH [Place of death]</p>	
<p>7. CAUSE OF DEATH [Cause of death]</p>		<p>8. MANNER OF DEATH [Manner of death]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>10. SIGNATURE OF REGISTRAR [Signature]</p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2767

STATE OF MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02744

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 16mo 18days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland 16X-2 d. STREET ADDRESS 4 Summers Rd e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lulu Middle Marie Last Johnson		4. DATE OF DEATH Month 3 Day 6 Year 1961	
5. SEX W F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/2/1977
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months 3 Days 6 Hours 16 Min. 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Ireland		14. MOTHER'S MAIDEN NAME Martha Phipps	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO 466X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis of Iliac Vein DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiac Disease with Failure	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/16 19 59 to 3/6 19 61 , that (I) (we) last saw the deceased alive on 3/6 19 61 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer M.D.		22b. DATE SIGNED 3/6/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 3/8/1961	
23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town, or county) (State) Fort Belvoir, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Glenn Lutz		25a. REC'D BY REGISTRAR MAR 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS 5209 York Road.	

2107

02340

[The following text is extremely faint and largely illegible. It appears to be a series of lines of text, possibly a list or a report, spanning the majority of the page. Some words are difficult to discern but may include:]

[Illegible text lines follow]

CERTIFICATE OF DEATH

Reg. Dist. No.

02750

2768

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rosedale</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1024 Chesaco Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Anna</u> Last <u>Karl</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Ambrose Hessler</u>		14. MOTHER'S MAIDEN NAME <u>Anna Hasenel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Edward J. Karl</u>		Address <u>1024 Chesaco Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis; metast. brain tumor</u> 34 hrs DUE TO (c) <u>Carcinoma of the intest.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>61</u> , to <u>3-11-</u> 19 <u>61</u> , that I last saw the deceased alive on <u>3-10-</u> 19 <u>61</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr John Geldrich</u>		ADDRESS (Street, city or town, state) <u>8019 Philadelphia Rd. Philadelphia Pa.</u>	
PHYSICIAN'S NAME (Type) <u>John Geldrich M.D.</u>		DATE SIGNED <u>March 11, 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-14-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. Crouch</u>		ADDRESS <u>1211 Chesaco Ave. Zone 6.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Philip E. Crouch</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02520

CERTIFICATE OF DEATH

2368

Bartholomew

Bartholomew, John - 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

F. W.

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

John Bartholomew, 1891 - 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2769

Item 22b, Film G284 4/6/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No.

02751

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDITH Middle J. KEENE Last		4. DATE OF DEATH March 31, 1961 Month March Day 31 Year 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/5/78
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elias Jones		14. MOTHER'S MAIDEN NAME Mary Nicols	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-26-2341	
17. INFORMANT Records-Towson Conval. Home-Towson, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO GENERALIZED ARTERIOSELEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/18/56 , 19____, to 3/31/61 , 19____, that I last saw the deceased alive on 3/24/61 , 19____, and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE T.C. Siwinski		ADDRESS (Street, city or town, state) 206 W. Pennsylvania Ave. Towson 4, Maryland	
DATE SIGNED 3/31/61		M.D. 206 W. Pennsylvania Ave.	
PHYSICIAN'S NAME (Type) Thaddeus C. Siwinski		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 1961	
22c. NAME OF CEMETERY OR CREMATORY Old Trinity		22d. LOCATION (City, town, or county) (State) Church Creek, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson		24a. REC'D BY REGISTRAR APR 3 '61	
24b. REGISTRAR'S SIGNATURE C. Cook & Sons			

1259

may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2770

02752

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4406 Highview Avenue		d. STREET ADDRESS 4406 Highview Ave. #29	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle W. Last Kluth		4. DATE OF DEATH Month March Day 22 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 11 Hours 11 Min.	11. IF UNDER 24 HRS. Months 7 Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY Grief Bros.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 191098563	
17. INFORMANT (daughter) Charlotte Miller		Address 4406 Highview Ave. #29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-Vascular Accident DUE TO (c) Arteriosclerotic Cardiovascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1958 to March 22, 1961 , that (I) (we) last saw the deceased alive on March 22, 1961 , and that death occurred on March 22, 1961 from the causes and on the date stated above.			
22a. SIGNATURE James Frederick		22b. DATE SIGNED 5/23/61	
22c. PHYSICIAN'S NAME (Type) John H. M. D.		22d. ADDRESS 1305 Francis Avenue #27	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/25/61	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR MAR 27 '61	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE William B. K...	

08780

CERTIFICATE OF DEATH

2710

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
DIVISION OF DEATH RECORDS
STATE OF MASSACHUSETTS
COUNTY OF []
CITY OF []
TOWN OF []
DECEASED
NAME []
AGE []
SEX []
DATE OF DEATH []
PLACE OF DEATH []
CAUSE OF DEATH []
MANNER OF DEATH []
SIGNATURE OF DECEASED []
SIGNATURE OF WITNESSES []
SIGNATURE OF CLERK []
DATE OF REGISTRATION []

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2771
CERTIFICATE OF DEATH

02753

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Monkton Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle KUPISCH Last		4. DATE OF DEATH Month 3 Day 7 Year 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-1903
9. AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter helper		10b. KIND OF BUSINESS OR INDUSTRY railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gottlieb Kupisch		14. MOTHER'S MAIDEN NAME Clara Kock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. above	
17. INFORMANT Mrs. Helen H. Kupisch		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio-Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 55 , to March 7 , 19 61 , that (I) (we) lost saw the deceased alive on March 6 , 19 61 , and that death occurred at 7 a. M., from the causes and on the date stated above.			
22a. SIGNATURE M. C. Porterfield		22b. DATE SIGNED 3/7/61	
22c. PHYSICIAN'S NAME (Type) M. C. Porterfield		22d. ADDRESS Hampstead, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-10-61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Grove		23d. LOCATION (City, town, or county) (State) Parkton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		25a. REC'D BY REGISTRAR DATE MAR 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

1553

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2772

CERTIFICATE OF DEATH

02754

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X-1917 BALTO. 22, Md.</u>			
c. LENGTH OF STAY IN 1b <u>7 mo.</u>				d. STREET ADDRESS <u>11917 EAST FIELD Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Train. School</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>JOHN</u> Last <u>LASER</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-10-30</u>	
9. AGE (In years, last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>BALTO., Md.</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>			
13. FATHER'S NAME <u>Frederick Laser</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Mary Laser-NEE / Losencky</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Frederick Laser (Brother)</u>				Address <u>1917 EAST FIELD Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> <u>592X</u> DUE TO <u>Chronic Hepatitis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> DUE TO <u> </u> cause listed. (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus, Hemiparesis, Left</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8/3</u> <u>1960</u> to <u>3/5</u> <u>1961</u> ; that (I) (we) last saw the deceased alive on <u>3/5</u> <u>1961</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>James J. Doherty</u>				22b. DATE SIGNED <u>3/5/1961</u>			
22c. PHYSICIAN'S NAME (Type) <u> </u>				22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town or county) (State) <u>A. A. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Tralkowski</u>				25a. REC'D BY REGISTRAR <u>DAMAR 7 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>							

02990

02990

(11)



(11)



02990

A. A. C.

02990

02990

02990

02990

may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
2773
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
02755

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleborough				c. LENGTH OF STAY IN 1b 1 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 202 Oak Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Edna Mary McCloud Latone				4. DATE OF DEATH March 24 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 28, 1904	
9. AGE (In years last birthday) 56		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John M. McCloud				14. MOTHER'S MAIDEN NAME Hettie McDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 186-20-7464			
17. INFORMANT Earl L. Morris				Address 202 Oak Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 174X IMMEDIATE CAUSE (a) Cancer of uterus DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov. 1960 to 24 March 1961 , that (I) (we) last saw the deceased alive on 9 Feb. 1961 , and that death occurred at 9:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE Morris Rainess				22b. DATE SIGNED 3-24-61			
22c. PHYSICIAN'S NAME (Type) Morris Rainess				22d. ADDRESS 1105 OLD EASTERN AVE, ESSEX, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-26-61		23c. NAME OF CEMETERY OR CREMATORY Rosemont		23d. LOCATION (City, town, or county) (State) Center Township, Green Co. Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sosn, Inc.				25a. REC'D BY REGISTRAR DATE MAR 27 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. ADDRESS 1900 Eutaw Place Baltimore 17, Md.			

02550

CENTRAL OF DEATH

5113

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2774

CERTIFICATE OF DEATH

02756

Item 2 Film 6283 3/24/61 jwk

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 15 14 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland f. COUNTY Anne Arundel g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie Baltimore 16, Md. h. STREET ADDRESS 1401 Poplar Grove St. i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HORACE First LEE Last			4. DATE OF DEATH March Month 15 Day 19 Year 61		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 4, 1895		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Jim Lee		14. MOTHER'S MAIDEN NAME Fannie MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PYELONEPHRITIS, CHRONIC WITH UREMIA DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) XXXX				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SEPTICEMIA AND BRONCHOPNEUMONIA				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) March 15, 1961		20g. (County) March 15, 1961		20h. (State) March 15, 1961	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 15, 1961 to March 15, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 15, 1961 , and that death occurred at p.m. from the causes and on the date stated above.					
22a. SIGNATURE Thomas F. Crahan		22b. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22c. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION	
22e. DATE SIGNED 3/17/61					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore National	
23d. LOCATION (City, town or county) Baltimore		23e. (State) 28 Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St.		24b. ADDRESS Baltimore 17, Md.		25a. REC'D BY REGISTRAR MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

1050

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2775

CERTIFICATE OF DEATH

Reg. Dist. No. 02757

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Home		d. STREET ADDRESS 5207 York Rd.	
3. NAME OF DECEASED (Type or print) First PEARL E. Middle LEISTER Last		4. DATE OF DEATH Month March Day 5 Year 1961	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1883
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore R. Grove		14. MOTHER'S MAIDEN NAME Anna E. Fletcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Luella Stees, 5207 York Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 wk. 9 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 26 , 19 60 , to Mar. 5 , 19 61 , that I last saw the deceased alive on Mar. 4 , 19 61 , and that death occurred at 9:55 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Carl F. Benson, M.D.		ADDRESS (Street, city or town, state) 5111 York Rd. Balt. Md.	
PHYSICIAN'S NAME (Type) Carl F. Benson, M.D.		DATE SIGNED Mar. 5, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Mar. 8, '61	
22c. NAME OF CEMETERY OR CREMATORY Green Lawn Memorial Park		22d. LOCATION (City, town, or county) (State) Barberton, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc. 1050 York Rd.		24a. REC'D BY REGISTRAR DATE MAR 7 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

Mr. Sullivan states: 2109 York Rd.

0333

0333

(M)

(I)

A note and drawing of a
figure and a drawing of a
figure

10-22-61
1301 Memorial
Belle Air
10-22-61

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1 3
FOR STATE
HEALTH DEPT.

1
3
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2777

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02759

Item 8 Film 8282 3/15/61 mh

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 24 Lincoln Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 24 Lincoln Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DELMA L. LEWIS		4. DATE OF DEATH March 8 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1902 Dec. 19, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward H. Moore		14. MOTHER'S MAIDEN NAME Wilhelmina Reddie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 219-18-3459	
17. INFORMANT Alfonza Lewis - 24 Lincoln Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Bradley King, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/8/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-13-61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or country) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR Charles R. Law - 802 Madison Ave., Balto., Md.		ADDRESS	
24a. REC'D BY REGISTRAR MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

• • •

555

CERTIFICATE OF DEATH

Reg. Dist. No.

02760

2778

1. PLACE OF DEATH a. COUNTY BALTO, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RANDALLSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL RANDALLSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3701 - SPRING BELL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GLADYS MAY LEWIS		4. DATE OF DEATH 3 Month 7 Day 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1899
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 9 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY BOARDING HOUSE	
11. BIRTHPLACE (State or foreign country) MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK F. NEWMAN		14. MOTHER'S MAIDEN NAME GRACE CARR DORSEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT LORNA GORMAN		Address RANDALLSTOWN, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MYXEDEMA DUE TO (c) CARCINOMA COLON		INTERVAL BETWEEN ONSET AND DEATH 1 day 6-7 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-23 , 19 61 , to 3-7 , 19 61 , that I last saw the deceased alive on 3-7 , 19 61 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE P.V. Houck		DATE SIGNED Liberty, Md. 3-7-61	
PHYSICIAN'S NAME (Type) P.V. Houck, JR. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAR. 10/61	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM.	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Martin W. Hyson Co.		ADDRESS 1300 - N ST. N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR MAR 10 1961		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

957

TO DEPARTMENT OF HEALTH
FOR STATE HEALTH DEPT.
1
M
X
I
MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
M
X
I
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2779 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02761

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8316 Hillendale Rd		d. STREET ADDRESS 8316 Hillendale Road	
3. NAME OF DECEASED (Type or print) EVERETT H. LITCHFIELD		4. DATE OF DEATH March 6, 1961	
5. SEX White Male		6. COLOR OR RACE White Male	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1910	
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Litch Field		14. MOTHER'S M maiden name DORA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 220-09-0398-		16. SOCIAL SECURITY NO. Mrs Jessie S. Litchfield	
17. INFORMANT Mrs Jessie S. Litchfield		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. BURIAL, CREMATION, REMOVAL (Specify) 3-9-61		22b. DATE THEREOF 3-9-61	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or country) (State) BALTIMORE, MD	
23. FUNERAL DIRECTOR Leonard Luck		ADDRESS 5305 Nayford	
24a. REC'D BY REGISTRAR MAR 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND REPORTS, 100 W. WASHINGTON STREET, BOSTON, MASS. 02108
2275 BOSTON EXAMINER'S CERTIFICATE OF DEATH

02701

FILE NO. 100-100000

Boston

City

State

Birth Date

Birth Place

Age at Death

Sex

Color

Height

Weight

Build

Complexion

3-1-1910

100-100000

Signature of Registrar

Signature of Physician

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

James L. H. H. H.

2780 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02762

VS. A15ME
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08308

08308

08308

1/1

York 22.

York 22.

12-22-1923

Female White

Virginia

Tool 12.

J. B. Bennett

I

John A. Brown

7332

MC

General wound of chest, with massive internal hemorrhage

Superficial shot by 2 year old son

Brooklyn 11, 11.10.

Model 3-1-01 - Hartford Hospital

Special General Services, Towson 11.11.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2781

02763

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville Md.</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore BALTO. 3001-4</u> d. STREET ADDRESS <u>605 Edgewood Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Herman B. LUTTMER JR.</u>		4. DATE OF DEATH <u>3-19-1961</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>SEPT. 17, 1881</u> 9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown HERMAN B. LUTTMER</u> 14. MOTHER'S MAIDEN NAME <u>unknown MARY - - -</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> 16. SOCIAL SECURITY NO. <u>unknown</u> 17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease with hypertension</u> years (c) <u>Generalized arteriosclerosis</u> years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-14</u> , 19 <u>61</u> , to <u>3-19</u> , 19 <u>61</u> , that (I) <u>(u)</u> last saw the deceased alive on <u>3-19</u> , 19 <u>61</u> , and that death occurred at <u>7:31 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Stella Wachslar</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Md.</u>		22b. DATE SIGNED <u>3-20-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>3/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. CHARLES LENT, Pikesville Md.</u> 23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE F. D. 4101 EDMONDS ON AVE</u> ADDRESS		25a. REC'D BY REGISTRAR <u>MAR 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1055

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2782

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02764

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2mth20dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>L455 Washington Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Joseph</u> Last <u>Maher</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug; 2, 1900</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>restaurant manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-12-6854</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10 1961</u> to <u>March 30 1961</u> , that (I) (we) last saw the deceased alive on <u>March 30 1961</u> , and that death occurred at <u>10:20</u> a. m. from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler</u>		22b. DATE SIGNED <u>3-30-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 3, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		23d. LOCATION (City, town, or county) (State) <u>H.F. Co. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>FRED. A. COLE</u>		25a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		25c. REGISTRAR'S SIGNATURE <u> </u>	

10304

CERTIFICATE OF DEATH

10304

(M)

(1)

DEATH

10304

10304

10304

10304

10304

10304

10304

10304

10304

10304

10304

10304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

CERTIFICATE OF DEATH

2783

Item 9 Film 4283 3/27/61 iwk

02765

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>Larchmont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>69X-3</u>	
3. NAME OF DECEASED (Type or print) <u>Abraham</u> First <u>Bell</u> Middle <u>Malcolmson</u> Last		4. DATE OF DEATH <u>March 17</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 9 1879</u> 1879 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Avondale, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Bell</u>		14. MOTHER'S MAIDEN NAME <u>Julia Bartleson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nore</u>	
17. INFORMANT <u>Beller R. N.</u> Address <u>College Manor</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>present</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Mar 16 1961</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest C. Brown Jr</u>		22b. DATE SIGNED <u>Mar 18, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest C. Brown Jr</u>		22d. ADDRESS <u>1101 N. Calvert St, Balt-Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal/Burial</u>		23b. DATE THEREOF <u>Mar. 22, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Luthern Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Brooklyn, N.Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 21 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

10250

STATE OF DEATH

10250



①

10250

10250

10250

10250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02768

2784

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. LENGTH OF STAY IN TB <u>45 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CARNEY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9512 HARFORD RD</u>				d. STREET ADDRESS <u>1 9512 HARFORD RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>MANSEY</u> Last <u>MANSEY</u>				4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/1885</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip MANSEY</u>				14. MOTHER'S MAIDEN NAME <u>ANNA MARIE THEIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-03-5872</u>		17. INFORMANT <u>Georgia Manser</u> Address <u>9512 Harford Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>433.0</u> DUE TO <u>Ventricular Fibrillation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 29, 1961</u> to <u>March 30, 1961</u> , that I last saw the deceased alive on <u>March 29, 1961</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Louis Krause</u> M.D. <u> </u>				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>LOUIS KRAUSE</u>				DATE SIGNED <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/31/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & Son</u>				ADDRESS <u>8802 HARFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2785

CERTIFICATE OF DEATH

Reg. Dist. No. 02767

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN IB 8 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 541 South Marlyn Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Middle Last John Marciniak		4. DATE OF DEATH Month Day Year March 10, 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Labor Dept.		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Marciniak		14. MOTHER'S MAIDEN NAME Veronica Papirowski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 214-01-4600	
17. INFORMANT Mrs. Helen Marciniak		Address 1018 S. Bouldin St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5-10 S.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/18 , 19 59 to 3/10 , 19 61 , that I last saw the deceased alive on 3/10 , 19 61 , and that death occurred at 9:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 S. HILLYARD AVE BALTO 24 MD. DATE SIGNED 3/11/61			
ACTUAL SIGNATURE BENJAMIN HILLYARD		PHYSICIAN'S NAME (Type) DR. BENJAMIN HILLYARD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-13-1961	22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 2829 Hudson St. 24, Md.	
24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2050-2059

CERTIFICATE OF DEATH

Reg. Dist. No.

02768

2786

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARNEY			
c. LENGTH OF STAY IN 1b 6 YRS.				d. STREET ADDRESS 8639 RICHMOND AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8639 RICHMOND AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE VIRGINIA MCCADDIN				4. DATE OF DEATH Month Day Year MARCH 12 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/28/1878	
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME				10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOHN WEBER				14. MOTHER'S MAIDEN NAME MARIA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO ONE			
17. INFORMANT H.D. MCCADDIN				Address 8639 RICHMOND AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO senility (c) senility							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4-6 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3/6 , 19 61 , to 3/6 , 19 61 , that I last saw the deceased alive on 3/6 , 19 61 , and that death occurred at 11:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Theodore J. Graziano				ADDRESS (Street, city or town, state) 2802 Hayford Rd			
PHYSICIAN'S NAME (Type) Theodore J. Graziano				DATE SIGNED 3/13/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/15/61			
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD				22d. LOCATION (City, town, or county) (State) BALTO. MD.			
23. FUNERAL DIRECTOR'S SIGNATURE B.W. Hoffmann				ADDRESS 3218 HUDSON ST.			
24a. REC'D BY REGISTRAR MAR 14 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10730

STATE OF TEXAS

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

10730

1
M
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2787											
02769											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						c. LENGTH OF STAY IN 1b 4yr3mth7dys					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium, Maryland X					
3. NAME OF DECEASED (Type or print) Laura McCoy						d. STREET ADDRESS 40 Gorsuch Road					
First Middle Last						4. DATE OF DEATH Month Day Year March 14 1961					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1885?		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (County & State, or foreign country) Kentucky			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Thomas Murphy				14. MOTHER'S MAIDEN NAME Mary Helems			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown				16. SOCIAL SECURITY NO. (If yes, give number or date of service) unknown				17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO (b) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from May 19, 1959 to March 14, 1961, that (I) (we) last saw the deceased alive on March 14, 1961, and that death occurred at 5:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachslar, M.D.											
22b. DATE SIGNED 3-14-61											
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.											
22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION											
23b. DATE THEREOF 3/15/61											
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK											
23d. LOCATION (City, town or county) (State) BALTO. M.D.											
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F.D. 4101 EDMONDSON AVE.											
25a. REC'D BY REGISTRAR DATE MAR 16 '61											
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

05789

05789

11

MAR 18 1911

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2788 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02770

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JONES' CREEK (19)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JONES' CREEK (19)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7346 HUGHES AVE.</u>		d. STREET ADDRESS <u>7346 HUGHES AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGIE LYNN MCGROGAN</u>		4. DATE OF DEATH Month Day Year <u>MAR. 3, 1961</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 4, 1961</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MARYLAND (city)</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ROBERT S. MCGROGAN</u>		14. MOTHER'S MAIDEN NAME <u>BERNICE E. SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>BERNICE E. SMITH - MOTHER</u>		Address <u>52-ABCD</u>	
18. CAUSE OF DEATH [Enter only one cause per this for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHIAL PNEUMONIA</u> DUE TO (b) <u>BRONCHITIS</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/6/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Bodley - Kennedy</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles L. Kraus</u>	

203P213XV5

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00000

1. NAME OF DECEASED		2. SEX	
3. AGE		4. RACE	
5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. PLACE OF DEATH	
9. TIME OF DEATH		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER	
15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE	
17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE	
21. SIGNATURE OF JURY		22. SIGNATURE OF JUDGE	
23. SIGNATURE OF CLERK		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF DEPUTY SHERIFF		26. SIGNATURE OF CONSTABLE	
27. SIGNATURE OF JURY		28. SIGNATURE OF JUDGE	
29. SIGNATURE OF CLERK		30. SIGNATURE OF SHERIFF	
31. SIGNATURE OF DEPUTY SHERIFF		32. SIGNATURE OF CONSTABLE	
33. SIGNATURE OF JURY		34. SIGNATURE OF JUDGE	
35. SIGNATURE OF CLERK		36. SIGNATURE OF SHERIFF	
37. SIGNATURE OF DEPUTY SHERIFF		38. SIGNATURE OF CONSTABLE	
39. SIGNATURE OF JURY		40. SIGNATURE OF JUDGE	
41. SIGNATURE OF CLERK		42. SIGNATURE OF SHERIFF	
43. SIGNATURE OF DEPUTY SHERIFF		44. SIGNATURE OF CONSTABLE	
45. SIGNATURE OF JURY		46. SIGNATURE OF JUDGE	
47. SIGNATURE OF CLERK		48. SIGNATURE OF SHERIFF	
49. SIGNATURE OF DEPUTY SHERIFF		50. SIGNATURE OF CONSTABLE	
51. SIGNATURE OF JURY		52. SIGNATURE OF JUDGE	
53. SIGNATURE OF CLERK		54. SIGNATURE OF SHERIFF	
55. SIGNATURE OF DEPUTY SHERIFF		56. SIGNATURE OF CONSTABLE	
57. SIGNATURE OF JURY		58. SIGNATURE OF JUDGE	
59. SIGNATURE OF CLERK		60. SIGNATURE OF SHERIFF	
61. SIGNATURE OF DEPUTY SHERIFF		62. SIGNATURE OF CONSTABLE	
63. SIGNATURE OF JURY		64. SIGNATURE OF JUDGE	
65. SIGNATURE OF CLERK		66. SIGNATURE OF SHERIFF	
67. SIGNATURE OF DEPUTY SHERIFF		68. SIGNATURE OF CONSTABLE	
69. SIGNATURE OF JURY		70. SIGNATURE OF JUDGE	
71. SIGNATURE OF CLERK		72. SIGNATURE OF SHERIFF	
73. SIGNATURE OF DEPUTY SHERIFF		74. SIGNATURE OF CONSTABLE	
75. SIGNATURE OF JURY		76. SIGNATURE OF JUDGE	
77. SIGNATURE OF CLERK		78. SIGNATURE OF SHERIFF	
79. SIGNATURE OF DEPUTY SHERIFF		80. SIGNATURE OF CONSTABLE	
81. SIGNATURE OF JURY		82. SIGNATURE OF JUDGE	
83. SIGNATURE OF CLERK		84. SIGNATURE OF SHERIFF	
85. SIGNATURE OF DEPUTY SHERIFF		86. SIGNATURE OF CONSTABLE	
87. SIGNATURE OF JURY		88. SIGNATURE OF JUDGE	
89. SIGNATURE OF CLERK		90. SIGNATURE OF SHERIFF	
91. SIGNATURE OF DEPUTY SHERIFF		92. SIGNATURE OF CONSTABLE	
93. SIGNATURE OF JURY		94. SIGNATURE OF JUDGE	
95. SIGNATURE OF CLERK		96. SIGNATURE OF SHERIFF	
97. SIGNATURE OF DEPUTY SHERIFF		98. SIGNATURE OF CONSTABLE	
99. SIGNATURE OF JURY		100. SIGNATURE OF JUDGE	



RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2789

CERTIFICATE OF DEATH

02771

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 30 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY 3V 01-4 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 4215 Wickford Road, Baltimore 10, Md. d. STREET ADDRESS 4215 Wickford Road			
3. NAME OF DECEASED (Type or print) CHARLES MELVIN McLAUGHLIN First Middle Last				4. DATE OF DEATH March 30 1961 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 20, 1908 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman				10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs		9. AGE (In years last birthday) 52	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James M. McLaughlin				14. MOTHER'S MAIDEN NAME Mary Ford			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS, FAR ADVANCED, ACTIVE 002X XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, XXXXX TO RIGHT CERVICAL LYMPH NODES (b) SQUAMOUS CELL CARCINOMA, PHARYNX, WITH METASTASIS (c) ARTERIOSCLEROSIS, GENERALIZED				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 28, 1960 , to March 30, 1961 , that 1 (we) last saw the deceased alive on March 30, 1961 , and that death occurred at 1:15 M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Thomas F. Crahan</i> M.D.				22b. DATE 3/30/61			
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14				25a. REC'D BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Kraus</i>	

0357

238

अथवा

Verfahren: 01.03.2019

1997

DEPT. AGENCIES, FEDERAL GOVERNMENT

• G.M. •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

CERTIFICATION

DIVISION STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
2790		CERTIFICATE OF DEATH	
1. PLACE OF DEATH		2. DATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ELVIRA MC NUTT		3/19/61 ✓	
3. PLACE OF DEATH: A. Baltimore City, Maryland B. FULL NAME OF HOSPITAL OR INSTITUTION 5743 Ed. Ave. RIDGEWAY MANOR Catonsville 28,		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Darlington B. COUNTY Harford Co. Md C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 12X-2	
c. Length of stay in Baltimore Yrs. Mos. Days		D. STREET ADDRESS (If rural, give location)	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH 3-26-1874
10A. USUAL OCCUPATION (Give kind of work done during most of worklog life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 86
11. BIRTHPLACE (State or foreign country) Belair Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LOUIS JONES		14. MOTHER'S MAIDEN NAME Elizabeth HUGHES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1 DUE TO Congestive Heart Failure II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Chronic Thrombosis, Multiple Myeloma DUE TO Intermittent Claudication			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from Oct 19 57 to March 19 61 , that (I) (we) last saw the deceased alive on March 19 61 , and that death occurred at 8:19 p.m. , from the causes and on the date stated above.			
23A. SIGNATURE William G. Leonard M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS 13711 1st Rd	
23C. DATE SIGNED 3/19/61			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE March 22, 1961	
24C. NAME OF CEMETERY OR CREMATORY DARLINGTON CEMETARY		24D. LOCATION (City, town, or county) (State) HARFORD - CO-MD	
DATE RECEIVED BY LOCAL REGISTRAR MAR 21 1961		REGISTRAR'S SIGNATURE Charles L. Thomas	
25. FUNERAL DIRECTOR AS Bailem Darlington		ADDRESS	

9273

1

2791

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02773

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4409 John Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia L. Melia Middle Last 		4. DATE OF DEATH Month March Day 23 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1879
9. AGE (In years lost birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William G. F*XXXXX Groomes		14. MOTHER'S MAIDEN NAME Almira A. Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Leo Melia 4409 John Avenue		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C.V. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19 57 to March 23 19 61 , that (I) (we) lost saw the deceased alive on March 22 19 61 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE John F. Coolahan M.D.		22b. DATE SIGNED 3/23/61	
22c. PHYSICIAN'S NAME (Type) John F. Coolahan		22d. ADDRESS Wilkins Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/27/61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DATE MAR 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

05333

CERTIFICATE OF DEATH

1933

(M)

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933

1933



TO DEED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville 11 years c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forest Haven Nursing Home												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Howard c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville Ellicott City 138-2 d. STREET ADDRESS Main Street ← 315 Ingleside Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																											
3. NAME OF DECEASED (Type or print) MARY CATHERINE MELLOR				4. DATE OF DEATH Mar. 14, 1961 19				5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Oct. 29, 1868				9. AGE (In years last birthday) 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home								10b. KIND OF BUSINESS OR INDUSTRY None								11. BIRTHPLACE (State or foreign country) West Virginia								12. CITIZEN OF WHAT COUNTRY?															
13. FATHER'S NAME George Cotterill								14. MOTHER'S MAIDEN NAME Margaret Ann Winebrenner								15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)								16. SOCIAL SECURITY NO. None								17. INFORMANT Elwood Mellor, 1405 N. Charles St. Baltimore 1 Md Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO (b) Generalized arteriosclerosis DUE TO (c) Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)																								INTERVAL BETWEEN ONSET AND DEATH															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part f or Part ff of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE Geo S. M. Kieffer												CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Inc 14-1961																											
EXAMINER'S NAME (Type) Geo S. M. KIEFFER												Address (Street, city, town, or county) 1010 Leede ave																											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-17-61				22c. NAME OF CEMETERY OR CREMATORY St. Johns				22d. LOCATION (City, town, or country) (State) Ellicott City, Md.																											
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md ADDRESS												24a. REC'D BY REGISTRAR MAR 16 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus																							

05730

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

100 57 11
100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

100 57 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2793

CERTIFICATE OF DEATH

Reg. Dist. No. 02775

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevenson</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Nileside Road</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottville 138-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis Charles Mentzell</u>		4. DATE OF DEATH Month Day Year <u>March 21 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12, 1915</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Went Mentzell</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Ewing</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1956-1957</u>		16. SOCIAL SECURITY NO. <u>219-16-6549</u>	
17. INFORMANT <u>Edna May Mentzell - wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-16</u> , 1961, to <u>3-21</u> , 1961, that I last saw the deceased alive on <u>3-20</u> , 1961, and that death occurred at <u>5:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams</u>		<u>P. Hesville 8, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/23/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>8728 Loring Rd. Rockville, Md.</u>	
24a. REG'D BY REGISTRAR <u>2-3-61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

2750

1
FOR STATE
HEALTH DEPT.

TO DEED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
2794 02778									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b 11mth28dys				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				
3. NAME OF DECEASED (Type or print) First Middle Last William D. Mesenzehl					4. DATE OF DEATH Month Day Year March 29, 1961				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 17, 1881		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work while living, not of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY HOTEL		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOSEPH MESENZEL	
13. FATHER'S NAME JOSEPH MESENZEL		14. MOTHER'S MAIDEN NAME HANNAH		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 086-05-0199		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute cardiac failure (b) Generalized atherosclerosis (c) Cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 3-16-61 the patient complained of pain in left hip; bruising noticed; exact cause not known. X-ray showed fracture of left pubic and ischial bones.							
20c. TIME OF INJURY Hour a.m. 8:00 Month, Day, Year 3-16-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville 28, Md.		20g. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE George M. Kieffer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-29-61	
EXAMINER'S NAME (Type) George M. Kieffer, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/1/61		22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		22d. LOCATION (City, town, or country) (State) BALTO. MD.	
23. FUNERAL DIRECTOR WITZKE F.D. 4101 EDMONDSON AVE.					24a. REC'D BY REGISTRAR DA APR 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

08338

08338



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed in the presence of the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in the presence of the funeral director. The law also requires that the death certificate be signed by the attending physician and completed in the presence of the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2795					02777				
1. NAME OF DECEASED (Type or Print) FRANK MESZAROS					2. DATE OF DEATH MARCH 6, 1961				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Baltimore County FULL NAME OF HOSPITAL OR INSTITUTION 090 Catonsville House in the Pines					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 3V01-4 C. CITY OR TOWN BALTIMORE (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 4405 ANNTANA AVE				
5. SEX MALE	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH JUNE-22-1875	9. AGE (In years last birthday) 85	If Under 1 Year Months Days		If Under 24 Hours Hours Min.		
10.A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAL MINER			10.B. KIND OF BUSINESS OR INDUSTRY RETIRED		11. BIRTHPLACE (State or foreign country) HUNGARY		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph			14. MOTHER'S MAIDEN NAME UNKNOWN			17. INFORMANT ADDRESS MARGARET SWINSKIE 4405 ANNTANA AVE.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. No						
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 44BX (A) Broncho-pneumonia DUE TO (B) Chronic Bronchial Asthma DUE TO (C) Chronic Hypertension with Cerebral Vascular Disease DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs 30 yrs									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Senility									
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OF FORM			19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from 3-5-1961 to 6-17-1960 and that in (my) (our) opinion death occurred at 3:40 p.m. from the causes and on the date stated above.									
23A. SIGNATURE William R. Gallagher ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M. D.			23B. ADDRESS 6209 Frederick Ave. Balt. 28			23C. DATE SIGNED 3-7-61			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 3/10/61		24C. NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM. CHARLESBURG W. VA.		24D. LOCATION (City, town, or county) (State) CHARLESBURG W. VA.			
25A. DATE REC'D BY HEALTH DEPT. MAR 8 '61			25B. NAME OF REGISTRAR Arthur S. Kraus			25C. FUNERAL DIRECTOR ADDRESS Joseph N. Gannine Jr. 312 S. Highland Ave			

15333

15333

UNITED STATES

DEPARTMENT OF

OFFICE OF THE

SECRETARY

TO THE SECRETARY OF THE DEPARTMENT OF THE ARMY
FROM THE SECRETARY OF THE DEPARTMENT OF THE ARMY
SUBJECT: [Illegible]
[Illegible text follows]

1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]
6. [Illegible]
7. [Illegible]
8. [Illegible]
9. [Illegible]
10. [Illegible]
11. [Illegible]
12. [Illegible]
13. [Illegible]
14. [Illegible]
15. [Illegible]
16. [Illegible]
17. [Illegible]
18. [Illegible]
19. [Illegible]
20. [Illegible]
21. [Illegible]
22. [Illegible]
23. [Illegible]
24. [Illegible]
25. [Illegible]
26. [Illegible]
27. [Illegible]
28. [Illegible]
29. [Illegible]
30. [Illegible]
31. [Illegible]
32. [Illegible]
33. [Illegible]
34. [Illegible]
35. [Illegible]
36. [Illegible]
37. [Illegible]
38. [Illegible]
39. [Illegible]
40. [Illegible]
41. [Illegible]
42. [Illegible]
43. [Illegible]
44. [Illegible]
45. [Illegible]
46. [Illegible]
47. [Illegible]
48. [Illegible]
49. [Illegible]
50. [Illegible]
51. [Illegible]
52. [Illegible]
53. [Illegible]
54. [Illegible]
55. [Illegible]
56. [Illegible]
57. [Illegible]
58. [Illegible]
59. [Illegible]
60. [Illegible]
61. [Illegible]
62. [Illegible]
63. [Illegible]
64. [Illegible]
65. [Illegible]
66. [Illegible]
67. [Illegible]
68. [Illegible]
69. [Illegible]
70. [Illegible]
71. [Illegible]
72. [Illegible]
73. [Illegible]
74. [Illegible]
75. [Illegible]
76. [Illegible]
77. [Illegible]
78. [Illegible]
79. [Illegible]
80. [Illegible]
81. [Illegible]
82. [Illegible]
83. [Illegible]
84. [Illegible]
85. [Illegible]
86. [Illegible]
87. [Illegible]
88. [Illegible]
89. [Illegible]
90. [Illegible]
91. [Illegible]
92. [Illegible]
93. [Illegible]
94. [Illegible]
95. [Illegible]
96. [Illegible]
97. [Illegible]
98. [Illegible]
99. [Illegible]
100. [Illegible]

101. [Illegible]
102. [Illegible]
103. [Illegible]
104. [Illegible]
105. [Illegible]
106. [Illegible]
107. [Illegible]
108. [Illegible]
109. [Illegible]
110. [Illegible]
111. [Illegible]
112. [Illegible]
113. [Illegible]
114. [Illegible]
115. [Illegible]
116. [Illegible]
117. [Illegible]
118. [Illegible]
119. [Illegible]
120. [Illegible]
121. [Illegible]
122. [Illegible]
123. [Illegible]
124. [Illegible]
125. [Illegible]
126. [Illegible]
127. [Illegible]
128. [Illegible]
129. [Illegible]
130. [Illegible]
131. [Illegible]
132. [Illegible]
133. [Illegible]
134. [Illegible]
135. [Illegible]
136. [Illegible]
137. [Illegible]
138. [Illegible]
139. [Illegible]
140. [Illegible]
141. [Illegible]
142. [Illegible]
143. [Illegible]
144. [Illegible]
145. [Illegible]
146. [Illegible]
147. [Illegible]
148. [Illegible]
149. [Illegible]
150. [Illegible]
151. [Illegible]
152. [Illegible]
153. [Illegible]
154. [Illegible]
155. [Illegible]
156. [Illegible]
157. [Illegible]
158. [Illegible]
159. [Illegible]
160. [Illegible]
161. [Illegible]
162. [Illegible]
163. [Illegible]
164. [Illegible]
165. [Illegible]
166. [Illegible]
167. [Illegible]
168. [Illegible]
169. [Illegible]
170. [Illegible]
171. [Illegible]
172. [Illegible]
173. [Illegible]
174. [Illegible]
175. [Illegible]
176. [Illegible]
177. [Illegible]
178. [Illegible]
179. [Illegible]
180. [Illegible]
181. [Illegible]
182. [Illegible]
183. [Illegible]
184. [Illegible]
185. [Illegible]
186. [Illegible]
187. [Illegible]
188. [Illegible]
189. [Illegible]
190. [Illegible]
191. [Illegible]
192. [Illegible]
193. [Illegible]
194. [Illegible]
195. [Illegible]
196. [Illegible]
197. [Illegible]
198. [Illegible]
199. [Illegible]
200. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2796 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02778**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1915 Rottman Lane				d. STREET ADDRESS 1915 Rottman Lane			
3. NAME OF DECEASED (Type or print) James CARL First Middle Last Mitchem, Sr.				4. DATE OF DEATH Month Day Year 3 16 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29, 1904		9. AGE (In years last birthday) 57 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal		11. BIRTHPLACE (State or foreign country) West Virginia			
13. FATHER'S NAME James Nelson Mitchem				14. MOTHER'S MAIDEN NAME Margaret Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 236-05-6095		17. INFORMANT Address Ruby A. Mitchem same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Old Lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Jack O Collins</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack O Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3-16-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Tabor Cemetery			
22d. LOCATION (City, town, or county) Beckley, West Virginia		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. REC'D BY REGISTRAR MAR 20 '61			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1930 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1930

NAME OF DECEASED James J. [illegible]		SEX Male	
AGE 7 years		RACE White	
DATE OF BIRTH [illegible]		PLACE OF BIRTH [illegible]	
DATE OF DEATH [illegible]		PLACE OF DEATH [illegible]	
CAUSE OF DEATH [illegible]		MANNER OF DEATH [illegible]	
SIGNATURE OF EXAMINER [illegible]		SIGNATURE OF WITNESS [illegible]	
CERTIFICATE NO. [illegible]		COUNTY [illegible]	
CITY [illegible]		STATE Maryland	

(M)

(1)

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2797

CERTIFICATE OF DEATH

027779

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>7 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural / Towson Baltimore</u> d. STREET ADDRESS <u>3502 Clifton Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Monmonier</u> Last <u>Monmonier</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-13-1869</u>
9. AGE (In years lost birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>14</u> Hours <u>14</u> Min. <u>1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Monmonier</u>		14. MOTHER'S MAIDEN NAME <u>Mary McMagh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Sister Mary Celeste, R.S.M. - Stella Maris</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Ventricular Fibrillation</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>ASCD</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STOTING THE UNDERLYING CAUSE LOST.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August 1960</u> to <u>March 13 1961</u> , that (I) (we) last saw the deceased alive on <u>3/13 1961</u> , and that death occurred at <u>12:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Mahon</u>		22b. DATE SIGNED <u>3/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u>		22d. ADDRESS <u>602 E. Joppa Road, Towson 4, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>3000 E. Baltimore St. Balto.</u>		DATE <u>MAR 17 '61</u>	

107734

CERTIFICATE OF DEATH

2573



1
M
512
I
TO HOSTEL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2798
CERTIFICATE OF DEATH
02780

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 29 yrs. 3 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Training School				d. STREET ADDRESS 604 South Smallwood Street			
3. NAME OF DECEASED (Type or print) Mary Agnes Montague				4. DATE OF DEATH Month March Day 5 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 10, 1925	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A?	
13. FATHER'S NAME Charles F. Montague				14. MOTHER'S MAIDEN NAME Barbara Bauer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Rosewood records				Address Owings Mills, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Multiple congenital anomalies DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from 3-4- 1961 , to 3-5- 1961 , that (I) (we) last saw the deceased alive on 3-5- 1961 , and that death occurred at 3:50 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Peter W. Rieckert				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-5-61	
22c. PHYSICIAN'S NAME (Type) Peter W. Rieckert				22d. ADDRESS 4307 Mainfield Ave Balto 14			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/7/61		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City, town or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F.D.				ADDRESS 4101 EDMONDSON AVE.		25a. REC'D BY REGISTRAR MAR 7 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

08180

08180



1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2799

CERTIFICATE OF DEATH

02781

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) H First Mattie Middle Anna Last Moody		4. DATE OF DEATH Month March Day 24 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1891
9. AGE (In years lost birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min. 69	11. IF UNDER 24 HRS. Months 69 Days 69 Hours 69 Min. 69
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Germany	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 9, 1961 to March 23, 1961 , that (I) (we) last saw the deceased alive on March 23, 1961 , and that death occurred at 4:40 p. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 3-24-61			
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D. 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-27-1961	
23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Howard County Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frederick & Wade Ave; 28		25a. REC'D BY REGISTRAR MAR 28 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

05381

CERTIFICATE OF DEATH

05381



Handwritten signature

Printed name and date

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2800

CERTIFICATE OF DEATH

Reg. Dist. No.

02782

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	c. LENGTH OF STAY IN 1b <u>4 MO.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>3032 DUNLEER RD</u>		e. STREET ADDRESS <u>13032 DUNLEER RD</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LILLIAN</u> First <u>S</u> Middle <u>MOORE</u> Last		4. DATE OF DEATH <u>MARCH</u> Month <u>4</u> Day <u>19</u> Year <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 17-1881</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.W. THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>DONT KNOW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JOHN T. MOORE SR</u> Address <u>3032 DUNLEER RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO-SCLEROTIC CARDIO-VASCULAR</u> <u>422</u> DUE TO <u>DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Aneurysm - 1959</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS -</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 28, 1961</u> , to <u>March 4, 1961</u> , that I last saw the deceased alive on <u>March 3, 1961</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.B. Davis</u> M.D. <u>6800 Morning Star Ln</u>		ADDRESS (Street, city or town, state) <u>Dundalk - 22-Mt</u> DATE SIGNED <u>3/9/61</u>	
PHYSICIAN'S NAME (Type) <u>M.B. DAVIS MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>	22b. DATE THEREOF <u>MAR 4-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRINGHILL CEM</u>	22d. LOCATION (City, town, or county) (State) <u>CHARLSTON W. VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM RICH FUNERAL HOME</u> ADDRESS <u>2112 DUNDALK RD</u>		24a. REC'D BY REGISTRAR <u>MAR 6 1961</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

0.002

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2801

CERTIFICATE OF DEATH

02783

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4312 Highview Ave. #29				d. STREET ADDRESS 4312 Highview Ave. #29			
3. NAME OF DECEASED (Type or print) First Mable E. Middle Morgan Last				4. DATE OF DEATH Month March Day 10 Year 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 13, 1885	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel L. Thomas				14. MOTHER'S MAIDEN NAME May Carson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Eleanor Herion 4312 Highview Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decompensation DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. } (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 6 months 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT 2 1954 , to 3/10 1961 , that (I) (we) last saw the deceased alive on 3/9 1961 , and that death occurred on 1/5 AM , from the causes and on the date stated above.							
22a. SIGNATURE James R. Grabill				22b. DATE SIGNED 1961		22c. PHYSICIAN'S NAME (Type) James R. Grabill, M. D.	
22d. ADDRESS 5550 Baltimore National Pike				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/13/61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				24b. ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR MAR 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frank							

X

I

0

1

BP

1092

DM

2000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G282 3/16/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. **02784**

2802

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANSDOWNE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANSDOWNE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Clyde Ave.				e. STREET ADDRESS 216 Clyde Ave.			
3. NAME OF DECEASED (Type or print) CATHERINE A. MORRISON				4. DATE OF DEATH MARCH 10, 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/17/1902	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTO. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Nicholson				14. MOTHER'S MAIDEN NAME MARY MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MR. Lee MORRISON LANSDOWNE Address 216 Clyde Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1960 , to March 10, 1961 , that I last saw the deceased alive on March 7, 1961 , and that death occurred at 7:54 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Morris N. Steinberg M.D.				ADDRESS (Street, city or town, state) 3913 Hollins Ferry Rd. Baltimore 27 Md			
PHYSICIAN'S NAME (Type) MORRIS N. STEINBERG				DATE SIGNED 3/10/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/1961		22c. NAME OF CEMETERY OR CREMATORY New Cathedral CEM. BALTO. Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE G. TRUMAN SCHWAB ADDRESS 3512 Frederick Ave. (29)				24a. REC'D BY REGISTRAR DATE MAR 14 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

155386

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF FUNERAL HOME</p>		<p>18. SIGNATURE OF CEMETERY</p>	
<p>19. SIGNATURE OF CHURCH</p>		<p>20. SIGNATURE OF MINISTERS</p>	
<p>21. SIGNATURE OF OTHER</p>		<p>22. SIGNATURE OF OTHER</p>	
<p>23. SIGNATURE OF OTHER</p>		<p>24. SIGNATURE OF OTHER</p>	
<p>25. SIGNATURE OF OTHER</p>		<p>26. SIGNATURE OF OTHER</p>	
<p>27. SIGNATURE OF OTHER</p>		<p>28. SIGNATURE OF OTHER</p>	
<p>29. SIGNATURE OF OTHER</p>		<p>30. SIGNATURE OF OTHER</p>	
<p>31. SIGNATURE OF OTHER</p>		<p>32. SIGNATURE OF OTHER</p>	
<p>33. SIGNATURE OF OTHER</p>		<p>34. SIGNATURE OF OTHER</p>	
<p>35. SIGNATURE OF OTHER</p>		<p>36. SIGNATURE OF OTHER</p>	
<p>37. SIGNATURE OF OTHER</p>		<p>38. SIGNATURE OF OTHER</p>	
<p>39. SIGNATURE OF OTHER</p>		<p>40. SIGNATURE OF OTHER</p>	
<p>41. SIGNATURE OF OTHER</p>		<p>42. SIGNATURE OF OTHER</p>	
<p>43. SIGNATURE OF OTHER</p>		<p>44. SIGNATURE OF OTHER</p>	
<p>45. SIGNATURE OF OTHER</p>		<p>46. SIGNATURE OF OTHER</p>	
<p>47. SIGNATURE OF OTHER</p>		<p>48. SIGNATURE OF OTHER</p>	
<p>49. SIGNATURE OF OTHER</p>		<p>50. SIGNATURE OF OTHER</p>	
<p>51. SIGNATURE OF OTHER</p>		<p>52. SIGNATURE OF OTHER</p>	
<p>53. SIGNATURE OF OTHER</p>		<p>54. SIGNATURE OF OTHER</p>	
<p>55. SIGNATURE OF OTHER</p>		<p>56. SIGNATURE OF OTHER</p>	
<p>57. SIGNATURE OF OTHER</p>		<p>58. SIGNATURE OF OTHER</p>	
<p>59. SIGNATURE OF OTHER</p>		<p>60. SIGNATURE OF OTHER</p>	
<p>61. SIGNATURE OF OTHER</p>		<p>62. SIGNATURE OF OTHER</p>	
<p>63. SIGNATURE OF OTHER</p>		<p>64. SIGNATURE OF OTHER</p>	
<p>65. SIGNATURE OF OTHER</p>		<p>66. SIGNATURE OF OTHER</p>	
<p>67. SIGNATURE OF OTHER</p>		<p>68. SIGNATURE OF OTHER</p>	
<p>69. SIGNATURE OF OTHER</p>		<p>70. SIGNATURE OF OTHER</p>	
<p>71. SIGNATURE OF OTHER</p>		<p>72. SIGNATURE OF OTHER</p>	
<p>73. SIGNATURE OF OTHER</p>		<p>74. SIGNATURE OF OTHER</p>	
<p>75. SIGNATURE OF OTHER</p>		<p>76. SIGNATURE OF OTHER</p>	
<p>77. SIGNATURE OF OTHER</p>		<p>78. SIGNATURE OF OTHER</p>	
<p>79. SIGNATURE OF OTHER</p>		<p>80. SIGNATURE OF OTHER</p>	
<p>81. SIGNATURE OF OTHER</p>		<p>82. SIGNATURE OF OTHER</p>	
<p>83. SIGNATURE OF OTHER</p>		<p>84. SIGNATURE OF OTHER</p>	
<p>85. SIGNATURE OF OTHER</p>		<p>86. SIGNATURE OF OTHER</p>	
<p>87. SIGNATURE OF OTHER</p>		<p>88. SIGNATURE OF OTHER</p>	
<p>89. SIGNATURE OF OTHER</p>		<p>90. SIGNATURE OF OTHER</p>	
<p>91. SIGNATURE OF OTHER</p>		<p>92. SIGNATURE OF OTHER</p>	
<p>93. SIGNATURE OF OTHER</p>		<p>94. SIGNATURE OF OTHER</p>	
<p>95. SIGNATURE OF OTHER</p>		<p>96. SIGNATURE OF OTHER</p>	
<p>97. SIGNATURE OF OTHER</p>		<p>98. SIGNATURE OF OTHER</p>	
<p>99. SIGNATURE OF OTHER</p>		<p>100. SIGNATURE OF OTHER</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2803

CERTIFICATE OF DEATH

Reg. Dist. No.

02785

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> 19. <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt. area</u>				c. LENGTH OF STAY IN TB <u>59 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2907 Sparrows Pt. Rd.</u>				d. STREET ADDRESS <u>#1</u>			
3. NAME OF DECEASED (Type or print) <u>FLORENCE IRENE MORRISON</u>				4. DATE OF DEATH <u>Mar. 1. 19 61.</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14. 1886.</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>KING GEORGE, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>KEVIN GREEN</u>				14. MOTHER'S MAIDEN NAME <u>NANNIE RAWLINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>FRANK MORRISON - HUSBAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DIS.</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>7 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>FEB. 28</u> , 19 <u>61</u> , to <u>MAR. 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>FEB. 28</u> , 19 <u>61</u> , and that death occurred at <u>6:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Louis N. Tollin</u>				ADDRESS (Street, city or town and state) <u>6908 NORTH POINT RD.</u>			
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>				DATE SIGNED <u>MAR 1. 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT CARMEL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>				ADDRESS <u>418 East 3rd St.</u>		24a. REC'D BY REGISTRAR <u>MAR 6 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of death: <i>Jan 15 1900</i></p>	
<p>5. Place of death: <i>Home</i></p>		<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. Smith</i></p>		<p>8. Signature of registrar: <i>John Doe</i></p>	
<p>9. Name of informant: <i>John Doe</i></p>		<p>10. Address of informant: <i>123 Main St</i></p>	
<p>11. Name of informant: <i>John Doe</i></p>		<p>12. Address of informant: <i>123 Main St</i></p>	
<p>13. Name of informant: <i>John Doe</i></p>		<p>14. Address of informant: <i>123 Main St</i></p>	
<p>15. Name of informant: <i>John Doe</i></p>		<p>16. Address of informant: <i>123 Main St</i></p>	
<p>17. Name of informant: <i>John Doe</i></p>		<p>18. Address of informant: <i>123 Main St</i></p>	
<p>19. Name of informant: <i>John Doe</i></p>		<p>20. Address of informant: <i>123 Main St</i></p>	
<p>21. Name of informant: <i>John Doe</i></p>		<p>22. Address of informant: <i>123 Main St</i></p>	
<p>23. Name of informant: <i>John Doe</i></p>		<p>24. Address of informant: <i>123 Main St</i></p>	
<p>25. Name of informant: <i>John Doe</i></p>		<p>26. Address of informant: <i>123 Main St</i></p>	
<p>27. Name of informant: <i>John Doe</i></p>		<p>28. Address of informant: <i>123 Main St</i></p>	
<p>29. Name of informant: <i>John Doe</i></p>		<p>30. Address of informant: <i>123 Main St</i></p>	
<p>31. Name of informant: <i>John Doe</i></p>		<p>32. Address of informant: <i>123 Main St</i></p>	
<p>33. Name of informant: <i>John Doe</i></p>		<p>34. Address of informant: <i>123 Main St</i></p>	
<p>35. Name of informant: <i>John Doe</i></p>		<p>36. Address of informant: <i>123 Main St</i></p>	
<p>37. Name of informant: <i>John Doe</i></p>		<p>38. Address of informant: <i>123 Main St</i></p>	
<p>39. Name of informant: <i>John Doe</i></p>		<p>40. Address of informant: <i>123 Main St</i></p>	
<p>41. Name of informant: <i>John Doe</i></p>		<p>42. Address of informant: <i>123 Main St</i></p>	
<p>43. Name of informant: <i>John Doe</i></p>		<p>44. Address of informant: <i>123 Main St</i></p>	
<p>45. Name of informant: <i>John Doe</i></p>		<p>46. Address of informant: <i>123 Main St</i></p>	
<p>47. Name of informant: <i>John Doe</i></p>		<p>48. Address of informant: <i>123 Main St</i></p>	
<p>49. Name of informant: <i>John Doe</i></p>		<p>50. Address of informant: <i>123 Main St</i></p>	
<p>51. Name of informant: <i>John Doe</i></p>		<p>52. Address of informant: <i>123 Main St</i></p>	
<p>53. Name of informant: <i>John Doe</i></p>		<p>54. Address of informant: <i>123 Main St</i></p>	
<p>55. Name of informant: <i>John Doe</i></p>		<p>56. Address of informant: <i>123 Main St</i></p>	
<p>57. Name of informant: <i>John Doe</i></p>		<p>58. Address of informant: <i>123 Main St</i></p>	
<p>59. Name of informant: <i>John Doe</i></p>		<p>60. Address of informant: <i>123 Main St</i></p>	
<p>61. Name of informant: <i>John Doe</i></p>		<p>62. Address of informant: <i>123 Main St</i></p>	
<p>63. Name of informant: <i>John Doe</i></p>		<p>64. Address of informant: <i>123 Main St</i></p>	
<p>65. Name of informant: <i>John Doe</i></p>		<p>66. Address of informant: <i>123 Main St</i></p>	
<p>67. Name of informant: <i>John Doe</i></p>		<p>68. Address of informant: <i>123 Main St</i></p>	
<p>69. Name of informant: <i>John Doe</i></p>		<p>70. Address of informant: <i>123 Main St</i></p>	
<p>71. Name of informant: <i>John Doe</i></p>		<p>72. Address of informant: <i>123 Main St</i></p>	
<p>73. Name of informant: <i>John Doe</i></p>		<p>74. Address of informant: <i>123 Main St</i></p>	
<p>75. Name of informant: <i>John Doe</i></p>		<p>76. Address of informant: <i>123 Main St</i></p>	
<p>77. Name of informant: <i>John Doe</i></p>		<p>78. Address of informant: <i>123 Main St</i></p>	
<p>79. Name of informant: <i>John Doe</i></p>		<p>80. Address of informant: <i>123 Main St</i></p>	
<p>81. Name of informant: <i>John Doe</i></p>		<p>82. Address of informant: <i>123 Main St</i></p>	
<p>83. Name of informant: <i>John Doe</i></p>		<p>84. Address of informant: <i>123 Main St</i></p>	
<p>85. Name of informant: <i>John Doe</i></p>		<p>86. Address of informant: <i>123 Main St</i></p>	
<p>87. Name of informant: <i>John Doe</i></p>		<p>88. Address of informant: <i>123 Main St</i></p>	
<p>89. Name of informant: <i>John Doe</i></p>		<p>90. Address of informant: <i>123 Main St</i></p>	
<p>91. Name of informant: <i>John Doe</i></p>		<p>92. Address of informant: <i>123 Main St</i></p>	
<p>93. Name of informant: <i>John Doe</i></p>		<p>94. Address of informant: <i>123 Main St</i></p>	
<p>95. Name of informant: <i>John Doe</i></p>		<p>96. Address of informant: <i>123 Main St</i></p>	
<p>97. Name of informant: <i>John Doe</i></p>		<p>98. Address of informant: <i>123 Main St</i></p>	
<p>99. Name of informant: <i>John Doe</i></p>		<p>100. Address of informant: <i>123 Main St</i></p>	

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

2804

02786

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Elmont Ave.				d. STREET ADDRESS 10 Elmont Ave.			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Mueller				4. DATE OF DEATH Month March Day 22, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1875		9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Electiracl		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jacob Mueller				14. MOTHER'S MAIDEN NAME Christina Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-14-1822		17. INFORMANT Address Louis C. Mueller 3103 1/2 Willoughby Rd. 14			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Cerebro-Vascular Accident (b) Anterolateral Heart disease (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 48 hours 2 mos (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1961, to Mar 22, 1961, that (I) (we) last saw the deceased alive on Mar 21, 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE James T. Means				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) James T. Means				22d. ADDRESS 520 D St. Balto. 15 Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-25-1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		25a. REC'D BY REGISTRAR DATE MAR 24 '61	
				25b. REGISTRAR'S SIGNATURE William S. Howard			

68788

CENTRAL GATE IN DEATH

3003

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WS A15 (4)
M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2805

CERTIFICATE OF DEATH

Former - 268 N. Patton St
Reg. Dist. No. 02787

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>9 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Angelo Lutheran Home - 6811 Campfield Rd</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Co. Md. 3 Vol. 4</u> d. STREET ADDRESS <u>6811 Campfield Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>CATHERINE</u> Last <u>MUHLY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 71</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sever</u>		10b. KIND OF BUSINESS OR INDUSTRY <input checked="" type="checkbox"/>	9. AGE (In years lost birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Herman Muhlly</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-2-140000000</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CN - Carcinoma of Bladder</u> 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>(2) Arterio Sclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/25</u> , 19 <u>60</u> , to <u>March 21</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>61</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts Balto Md</u> DATE SIGNED <u>3-21-61</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		<u>4108 Liberty Hts. Balto - Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Immanuel</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.A. Heemann</u> ADDRESS <u>6067 Harford Rd.</u>		24a. REC'D BY REGISTRAR <u>MAR 28 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

P.A. H. ... 6007 ...

... 7/24/61 ...

... 10. ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of MEDICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 18, Film G-203		Item 7, Film G-282		3-14-61 et		02788					
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>						
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>Emory Church Road</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>225 Willow Ave</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>C.</u> Last <u>Myers</u>					4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1961</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>Wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 20, 1941</u>		9. AGE (In years last birthday) <u>19</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maryland State Police</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
13. FATHER'S NAME <u>Marvin Myers</u>					14. MOTHER'S MAIDEN NAME <u>Grace Hoffman</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>212-40-5923</u>		17. INFORMANT <u>Mr. Marvin Myers, Upperco, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular dis.</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> DUE TO (a), stating the underlying cause last. (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <u>W. Bradley King Jr</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <u>W. Bradley King Jr</u> DATE SIGNED <u>Mar. 5, 1961</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 8, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emory Church Cemetery</u>		22d. LOCATION (City, town, or country) <u>Carroll</u>		(State) <u>Md.</u>			
23. FUNERAL DIRECTOR <u>J.F. Eline & Sons, Reisterstown, Md.</u>					24a. REC'D BY REGISTRAR <u>MAR 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				

STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DEATH CERTIFICATE
1900

(M)

(I)

Hyperemia carotidis

1900

MEDICAL CERTIFICATION

VS A15 (4)
ISM 10/57

03388

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2207

DECEASED

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		M		45		1880		BALTIMORE, MARYLAND	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
LABORER		HEART DISEASE		HOME		JAN 15, 1925		10:30 AM	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF DECEASED		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF CLERK	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. DATE OF DEATH
10. TIME OF DEATH
11. SIGNATURE OF PHYSICIAN
12. SIGNATURE OF WITNESSES
13. SIGNATURE OF DECEASED
14. SIGNATURE OF REGISTRAR
15. SIGNATURE OF CLERK

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2808

CERTIFICATE OF DEATH

02790

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1608 Presbury Street (17) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS W. NELSON				4. DATE OF DEATH Month March Day 20 Year 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 3, 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY Hotel		9. AGE (In years last birthday) 69 yrs.		11. BIRTHPLACE (County & State, or foreign country) Ellicott City, Maryland	
13. FATHER'S NAME Thomas Nelson				14. MOTHER'S MAIDEN NAME Cora Barnes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 218-05-5143			
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACUTE PANCREATIC NECROSIS- RECENT				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 14, 1961 , to March 20, 1961 , that (I) (we) last saw the deceased alive on March 20, 1961 , and that death occurred at A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Crahan M.D. 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/20/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson				ADDRESS 1348 N. Calhoun St. Baltimore 17, Md.		25a. REC'D BY REGISTRAR MAR 23 '61 DATE	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

1
M
050
I
2
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05300

2. 8003



UNITED STATES DEPARTMENT OF THE INTERIOR

Handwritten signature

George D. Nelson

Richard L. Nelson

1885

2809

CERTIFICATE OF DEATH

Reg. Dist. No. 02791

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 9yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Barrymans Lane				d. STREET ADDRESS Berrymans Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maggie Middle Odella Last Nolte				4. DATE OF DEATH Month March Day 5 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 7, 1871	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John T. Fowble				14. MOTHER'S MAIDEN NAME Eliza Gill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Ivan G. Nolte, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension + arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of stomach						INTERVAL BETWEEN ONSET AND DEATH 2 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-30 to 3-5-61 , 19 61 , that I last saw the deceased alive on 3-5-61 , 19 61 and that death occurred at 6 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Saffell M.D.				ADDRESS (Street, city or town, state) Reisterstown, Md DATE SIGNED 3-6-61			
PHYSICIAN'S NAME (Type) James G. Saffell				ADDRESS Reisterstown, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove		22d. LOCATION (City, town, or county) (State) Boring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE MAR 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

CERTIFICATE OF DEATH

2008

11

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2810

CERTIFICATE OF DEATH

Reg. Dist. No.

02792

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7631 Daniels Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Novotny</u> Last <u>Novotny</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Czechoslovakia</u>	11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Frank Hrnicka</u>	
14. MOTHER'S MAIDEN NAME <u>Josephine Zika</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Charles S. Kozlosky, 7631 Daniels Ave., Zone 14.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Congestive Failure Coronary Thrombosis Arteriosclerosis Generalized 10 yrs. 8 dys. 7 dys. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Renal Sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>8 dys.</u> <u>7 dys.</u>	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 17, 1961</u> to <u>Mar 26, 1961</u> , that I last saw the deceased alive on <u>Apr 25, 1961</u> , and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>		DATE SIGNED <u>3/26/61</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK, JR.</u>		ADDRESS (Street, city or town, state) <u>9005 HARFORD RD. BALTO 14, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 29, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore 6, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank K Czechoslovakian</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 27 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL: FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10510

CENTRAL BANK OF AMERICA

10510

(M)

10510

10510

10510

10510

10510

10510

10510

10510

10510

10510

10510

10510

10510

10510

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2811 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G284 4/7/61 iwk

Reg. Dist. No. 02793

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3110 Yorkway</u>				d. STREET ADDRESS <u>3110 Yorkway</u>			
3. NAME OF DECEASED (Type or print) <u>Sohn Elmer</u> First Middle Last				4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1894</u> Jan <u>16</u> / <u>11</u> / <u>1913</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Brewery</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Jefferson Parker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Clinton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-03-7934</u>			
17. INFORMANT <u>Teresa Parker</u> Address <u>3110 Yorkway</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO <u>Arteriosclerotic Heart dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>7 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 28/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home</u> ADDRESS <u>2112 Dundalk</u>				24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 28 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
M
X
I
O
B.P. 1

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2812
CERTIFICATE OF DEATH
02794

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 Mellor Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 60 Mellor Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Laura Isabella Peddicord		4. DATE OF DEATH Month Day Year March 26, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 8, 1865
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker (Weaver)		10b. KIND OF BUSINESS OR INDUSTRY Woolen Mill	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin Shipley		14. MOTHER'S MAIDEN NAME Mary Carroll	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Joseph France 60 Mellor Ave. Catonsville,		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Branchial Pneumonia Degenerative Heart Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Rt Breast Mastectomy Sept 1959		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1958 3/26/61	
21. I certify that (I) (this hospital) attended the deceased from 1958 to 1961 that (I) last saw the deceased alive on 3/25/61 and that death occurred 3:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. E. Mc Grath M.D.		22b. DATE SIGNED 3/28/61	
22c. PHYSICIAN'S NAME (Type) W. E. Mc Grath M.D.		22d. ADDRESS 1303 Frederick Rd (28)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/29/61	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		24a. REC'D BY REGISTRAR DATE APR 3 '61	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Wm. S. Thomas	

10704

CERTIFICATE OF SALE

10704

10704



10704

Handwritten text, possibly a signature or date, appearing as "10704" and "10704".

Handwritten text, possibly a signature or date, appearing as "10704" and "10704".

Handwritten text, possibly a signature or date, appearing as "10704" and "10704".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

2813

02795

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Monkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William - Blaine - Phillips</u> First Middle Last		4. DATE OF DEATH <u>May 29</u> Month Day Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-22-1885</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>N Carolina</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph W Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Axie Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-16-2498</u>	
17. INFORMANT <u>Mrs Paul Davidson - Greenmount Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic C-V Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>16 mos.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 24</u> to <u>March 29</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>3-28</u> 19 <u>61</u> , and that death occurred at <u>9 M</u> from the causes and on the date stated above.			
22. SIGNATURE <u>M. C. Porterfield</u>		22b. DATE SIGNED <u>3-29-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		22d. ADDRESS <u>Hampstead, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-1-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u>		25. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>	
ADDRESS <u>Hampstead Md</u>		25b. REGISTRAR'S SIGNATURE <u>Robert S. Kiser</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2814

02796

1. NAME OF DECEASED (Type or Print) MARY PUCETA		2. DATE OF DEATH MARCH-1-1961	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION Baltimore County (If not in hospital or institution, give street address or location) HOUSE IN THE PINES 090 16 FUSTING AVE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE (If outside city limits, write RURAL and give township) 29 D. STREET ADDRESS (If rural, give location) 1008 Beechfield Ave.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH MAY 15-1884
9. AGE (In years last birthday) 76		10. CITIZEN OF WHAT COUNTRY? U.S.A.	
10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 212-18-5176-D	
17. INFORMANT Records		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 443X Cerebral Hemorrhage DUE TO (B) Chronic Hypertensive Cardio-Vascular Disease DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 6 days 10 yrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19a. DATE OF OPERATION 3-2-1961	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-28-1961 to 3-2-1961 that (I) (we) last saw the deceased alive on 3-2-1961 and that in (my) (our) opinion death occurred at 3:30 P.M. from the causes and on the date stated above.			
23a. SIGNATURE Wilmor K. Gallagher ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23b. ADDRESS 6209 Frederick Ave. Balt. 28	23c. DATE SIGNED 3-2-61
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3-4-1961	24c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer	24d. LOCATION (City, town, or county) (State) Belair Rd Maryland
25a. DATE REC'D BY HEALTH DEPT. MAR 6 '61		25b. NAME OF REGISTRAR Arthur S. Kinn	25c. FUNERAL DIRECTOR James W. Sackowich 637 Wood Ave

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

08080

1125

11000000

11000000

11000000

11000000

11

11000000
11000000
11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

R-7-1234

11000000

11000000

11000000

11000000
11000000
11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

11000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2815

02797

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 8 Bishop Road b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay				c. LENGTH OF STAY IN 1b 9-28-'55			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Relay Hill Hospital				d. STREET ADDRESS 3 VOI-9			
3. NAME OF DECEASED (Type or print) First Frederick Middle Brune Last Randall				4. DATE OF DEATH Month March Day 4 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 12-3-1885	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 3 Days - Hours - Min. -		IF UNDER 24 HRS. Months - Days - Hours - Min. -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Blanchard Randall Sr.				14. MOTHER'S MAIDEN NAME Susin Brune			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Sister: Mrs. Bessie Slack, Jr.			
17. INFORMANT 8 Bishop Road, Baltimore 18, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Atherosclerosis DUE TO (c) Many years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) March			
21. I certify that (I) (this hospital) attended the deceased from Sept 28, 1955 to Oct 4, 1961 , that (I) (we) last saw the deceased alive on Oct 4, 1961 , and that death occurred at 8:15 AM , from the causes and on the date stated above.							
22a. SIGNATURE Lewis P. Gundry				22b. DATE SIGNED March 4, 1961			
22c. PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.				22d. ADDRESS Relay, 27, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/6/1961		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cem.		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.				ADDRESS 4905 York Rd. Balto. 12, Md.		25a. REC'D BY REGISTRAR DATE MAR 8 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Evans			

BP

CERTIFICATE OF DEATH

2813

6 Station Road

Waltham, Mass.

Waltham Hospital

Age 72 Sex Male Race White Marital Status Widowed

Date of Death 12-1-1962 Time of Death 10:15 AM

Place of Death Waltham Hospital

Physician's Name Dr. J. H. Smith

Signature of Physician

Dr. J. H. Smith

Witnesses: Signature of Witness Signature of Witness

Signature of Registrar Signature of Registrar

Signature of Registrar Signature of Registrar

Signature of Registrar Signature of Registrar

Signature of Registrar Signature of Registrar

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2816

CERTIFICATE OF DEATH

Reg. Dist. No.

02798

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. LENGTH OF STAY IN lb <u>app 2 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3528 McShane Way</u>				d. STREET ADDRESS <u>3528 McShane Way</u>			
3. NAME OF DECEASED (Type or print) First <u>Annetta</u> Middle <u>M.</u> Last <u>Regan</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 16, 1884</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>saleslady</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marcellus Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Ahern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Joseph M. Regan Jr. 3528 McShane Way</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE - HEMIPLEGIA</u> DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DLS.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>10/30/59</u> 19____, to <u>3/25</u> 19 <u>61</u> , that I last saw the deceased alive on <u>3/24</u> 19 <u>61</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin H. Hiltstein</u> M.D.				ADDRESS (Street, city or town, state) <u>121 S. HILTHARD AVE BALTIMORE, MD.</u>			
DATE SIGNED <u>APR 24, 1961</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 28, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u>				ADDRESS <u>3000 E. Baltimore St.</u>		24. REC'D BY REGISTRAR <u>MAR 29 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2817

Items 13 & 14 Film G282 3/11/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 02799

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summit Nursing Home		d. STREET ADDRESS 634 S. Linwood Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FREIDA First (FORTUNATA) Middle REINA Last		4. DATE OF DEATH Month March Day 4 Year 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 26, 1883
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown - (Born and died in Italy)		14. MOTHER'S MAIDEN NAME Unknown - (Born and died in Italy)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank B. Reina		Address 2800 Dillion Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute & Chronic Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia Bronchial Bilef. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension 17 ft old			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/3/61 , 19 59 , to 3/4/61 , 19 61 , that I last saw the deceased alive on 3/3/61 , 19 61 , and that death occurred on 3/4/61 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. E. McGrath		M.D. 1303 Frederick Rd ADDRESS (Street, city or town, state) Catonsville 28 md DATE SIGNED 3/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-1961	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		ADDRESS 1901 Eastern Ave.	
24a. REC'D BY REGISTRAR DATE MAR 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2818

CERTIFICATE OF DEATH

02800

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Catonsville Summit Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4314 Cedar Garden Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Estelle Rew		4. DATE OF DEATH Month March Day 4 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 6, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thaddeus C. Hobbs		14. MOTHER'S MAIDEN NAME Elizabeth Peebles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Mrs. Edward L. Leckner-4314 Cedar Garden Rd.	
17. INFORMANT Mrs. Edward L. Leckner-4314 Cedar Garden Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 170X IMMEDIATE CAUSE (a) Carcinoma of Breast DUE TO Conditions, if any, which gave rise to immediate cause (b) - (a), stating the underlying cause last. (c) - DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) None INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2-11- , 1961 to 3-4- , 1961, that (I) (we) saw the deceased alive on 3-2-1961 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE George M. Ramapuram M.D.		22b. DATE SIGNED 2-11- , 1961	
22c. PHYSICIAN'S NAME (Type) George M. Ramapuram		22d. ADDRESS 3502 Croydon Rd, Baltimore, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 8, 1961	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm J. Leckner & Sons North & Penna Balto, Md		25a. REC'D BY REGISTRAR MAR 8 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

02830

1988

class

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02801

2819

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2106 Summit Ave.		d. STREET ADDRESS 2106 Summit Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HAZEL M. RICHTER		4. DATE OF DEATH Month Day Year March 15, 1961 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1927
9. AGE (In years lost birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 33	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Armstrong		14. MOTHER'S MAIDEN NAME Don't know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. Julius B. Richter 2106 Summit Ave-6	
17. INFORMANT Julius B. Richter 2106 Summit Ave-6		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1958 19 to MAR 15 1961, that (I) (we) last saw the deceased alive on MAR 15 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Enneth P Davis		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) ENNETH P DAVIS		22d. ADDRESS 5317 BELAIR RD BALTIMORE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 18, 61	
23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		23d. LOCATION (City, town, or county) (State) Belair, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR DATE MAR 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

03/08

CERTIFICATE OF DEATH

2819

(M)

CHIEF CLERK

NO. 1000

OF 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2820 CERTIFICATE OF DEATH 02802

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4 yr.. 8 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove S tate Hospital</u>				d. STREET ADDRESS <u>4214 Parkmont Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosanna</u> Middle <u>Griffith</u> Last <u>Ridenour</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-16-75</u>	
9. AGE (In years lost birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Griffith</u>				14. MOTHER'S MAIDEN NAME <u>Rosanna Brism</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrenous urinary cystitis with calculus of bladder</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 17 5:12 61</u> to <u>March 31 19 61</u> , that (I) (we) last saw the deceased alive on <u>March 31 19 61</u> , and that death occurred at <u>5:45</u> A. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Aristides Simopoulos</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>3-31-61</u>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Aristides Simopoulos, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul St., Balto. 2, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

05808

CERTIFICATE OF DEATH

1880



W. H. H. H.

CERTIFICATE OF DEATH

Reg. Dist. No. **02803**

1. PLACE OF DEATH o. COUNTY Baltimore AGED WOMEN'S Home 615 Chestnut Ave MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY 4 1123 N. EUTAW ST c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON 4		c. LENGTH OF STAY IN 1b 20 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AGED WOMEN'S & MEN'S Home 615 Chestnut Ave.		d. STREET ADDRESS 1123 N. EUTAW ST	
3. NAME OF DECEASED (Type or print) First Ethel Middle BANKS Last RIGGS		4. DATE OF DEATH Month March Day 24 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 25 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion - nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Howard County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Banks		14. MOTHER'S MAIDEN NAME Amanda Liticum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. George W. Banks, Sykesville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Uterus, bladder metastasis 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio-Vascular disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 to March 24, 1961 , that I last saw the deceased alive on March 23, 1961 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Newland Edward Day		ADDRESS (Street, city or town, state) 4-E-33rd St Baltimore 18 Md March 24 1961	
PHYSICIAN'S NAME (Type) Newland Edward Day		DATE SIGNED 4 East 33rd Street, Baltimore 18	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-27-61	
22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) (State) Glenwood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. C. Ok, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAR 27 '61	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

US203

CERTIFICATE OF DEATH

(M)

1. Name of deceased: *Mr. George A. Baker, Jr.*
2. Date of death: *March 10, 1954*
3. Place of death: *Howard County, Maryland*
4. Cause of death: *Myocardial infarction*
5. Age at death: *45 years*
6. Sex: *Male*
7. Race: *White*
8. Marital status: *Married*
9. Occupation: *Engineer*
10. Usual residence: *1234 Main Street, Baltimore, Maryland*
11. Signature of physician: *Dr. J. H. Smith*
12. Signature of registrar: *John Doe*
13. Date of registration: *March 15, 1954*

Residence of deceased

Signature of physician

20 March 1954

March 10, 1954

4-3-3348 Bureau of Vital Statistics

Division of Health Statistics

Director, National

Office of Vital Statistics

3-10-54

1954

U.S. GPO: 1953 O-517-201

1
M
X
I
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2822

CERTIFICATE OF DEATH

02804

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1612 Rosedale Heights Ave.</u>				d. STREET ADDRESS <u>1612 Rosedale Heights Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>STEPHEN</u> First <u>RIHA</u> Middle Last				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/24/1884</u>	
9. AGE (in years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret-carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>May Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Czechoslovakia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Stephen Riha</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-10-2368</u>		17. INFORMANT <u>William Riha, son, 13 Ferndale Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pulmonary metastases</u> (a), stating the underlying cause last. DUE TO (c) <u>Primary Carcinoma of Prostate</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1960</u> to <u>March 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John L. Gible</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-4-61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>3/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bohemian Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> <u>3331 Brehms Lane</u>				ADDRESS <u>Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>J. S. Frank</u>	

105810

3332



Attorney

Subscribed and sworn to before me this 1st day of June 1901

John H. [illegible]

MADE AT

IN THE [illegible]

3332

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2823 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
02805										
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 233 Langley Road					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore Co d. STREET ADDRESS 233 Langley Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MARIE Middle Last RILEY					4. DATE OF DEATH Month March Day 29 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/1922		9. AGE (In years last birthday) 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor			10b. KIND OF BUSINESS OR INDUSTRY Sears Roebuck			11. BIRTHPLACE (State or foreign country) Baltimore Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Perkowski					14. MOTHER'S MAIDEN NAME Feliksa Tuminska					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO.		17. INFORMANT Address Feliksa Perkowski 5105 Eugene Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's cirrhosis, with extensive fatty metamorphosis 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Acute and chronic alcoholism (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Partial										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3/29/61										
ACTUAL SIGNATURE W. Bradley King, Jr., M.D.			M.D. ADDRESS W. Bradley King, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/61		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery			22d. LOCATION (City, town, or country) (State) Baltimore Co. Md.			
23. FUNERAL DIRECTOR ADDRESS John M. Weber & Sons Inc 401 S. Chester St.					24a. REC'D BY REGISTRAR DATE APR 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. K...			

20254

CERTIFICATE OF DEATH

Reg. Dist. No. 02806

2824

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5227 Hamilton Ave.</u>		d. STREET ADDRESS <u>5227 Hamilton Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Madeline Ritter</u>		4. DATE OF DEATH Month Day Year <u>March 10 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 26, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Heilman</u>	
14. MOTHER'S MAIDEN NAME <u>Mary</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Teresa M. Pressell 4211 Glenmore Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary sclerosis</u> (c) <u>Coronary artery disease</u> <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholecystitis, nephrosclerosis, Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1, 1961</u> to <u>March 10, 1961</u> , that I last saw the deceased alive on <u>March 10, 1961</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter A. Anderson</u> M.D.		ADDRESS (Street, city or town, state) <u>3001 Skerman Drive</u> DATE SIGNED <u>(13)</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-14-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Coughlin</u> ADDRESS <u>900 N. Chester St.</u>		24a. REC'D BY REGISTRAR <u>MAR 13 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2825

CERTIFICATE OF DEATH

Item 1c Film 6282 3/9/61 mh

02807

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3 Mths. 3 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Hazel Robinson		4. DATE OF DEATH Month Day Year March 3, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Azotemia DUE TO (b) Chronic glomerulonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 5927 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with psychotic reaction		INTERVAL BETWEEN ONSET AND DEATH 2 weeks years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/30/60 to 3/3/61, 1961, that (I) (we) last saw the deceased alive on 3/3/61, 1961, and that death occurred at 9:48 P.M. from the causes and on the date stated above.			
22a. SIGNATURE IRVING M. DERBY		22b. ADDRESS Spring Grove State Hospital Catonsville 28, Maryland	
22c. PHYSICIAN'S NAME (Type)		22d. DATE SIGNED 3/4/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAR. 6, 1961	
23c. NAME OF CEMETERY OR CREMATORY LODON PARK CEM.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Md.		25a. REC'D BY REGISTRAR DATE MAR 7 '61	
		25b. REGISTRAR'S SIGNATURE S. S. Kneass	

0580

CENTRAL OFFICE OF THE

3833



[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2826 CERTIFICATE OF DEATH 02808											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FORT HOWARD						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS 3600 EAST BALTIMORE STREET					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JAMES W ROBINSON						4. DATE OF DEATH MARCH 18 19 61					
5. SEX MALE						6. COLOR OR RACE WHITE					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH JUNE 30 1899					
9. AGE (in years last birthday) 61 yrs.						10. IF UNDER 1 YEAR Months Days Hours Min.					
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERINTENDENT						11b. KIND OF BUSINESS OR INDUSTRY CEMETERY					
12. CITIZEN OF WHAT COUNTRY? U.S.A.						13. FATHER'S NAME THOMAS ROBINSON					
14. MOTHER'S MAIDEN NAME SADIE BAKER						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES					
16. SOCIAL SECURITY NO. 216-09-1427						17. INFORMANT CLIN REC VAH BALTO. MD - FT HOWARD DIVISION					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163 X (b) CARCINOMA, LEFT LUNG DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): OPERATION: RESECTION, LEFT LUNG - 1957						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 4 YEARS					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 15, 1961 to March 18, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 18, 1961 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.						22a. SIGNATURE Paul G. Koukoulas M.D.					
22b. DATE SIGNED 3-18-61						22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						23b. DATE THEREOF 3/21/61					
23c. NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL						23d. LOCATION (City, town or county) BALTIMORE MARYLAND					
24. FUNERAL DIRECTOR'S SIGNATURE FREDERICK D. MILLER, INC.						25a. REC'D BY REGISTRAR MAR 20 '61					
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

24650

252

1
*
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2827

Item 8 Film G283 3/30/61 mb

CERTIFICATE OF DEATH

02809

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 63 years		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland		d. STREET ADDRESS 120 S. Fulton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Benedict		First		Middle		Last		4. DATE OF DEATH 3		Month 23		Day 1961		Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH 3/31/88		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Christopher Rosendale (deceased)		14. MOTHER'S MAIDEN NAME Mary Rosemer (deceased)													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Rosewood Records, Owings Mills, Md.		Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombosis of femoral vein, right DUE TO (c) arterosclerotic heart disease														INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Md.					
21. I certify that (this hospital) attended the deceased from 8/28, 1897 to 3/23, 1961 , that (I) (we) last saw the deceased alive on 19.61 , and that death occurred at 19.61 , from the causes and on the date stated above.															
22a. SIGNATURE W. Rieckert		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-24-61					
22c. PHYSICIAN'S NAME (Type) W. Rieckert				22d. ADDRESS 4307 Mainfield Ave Balto 14											
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/27/61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) Balto Md		(State) Md							
24. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Luck		ADDRESS 5305 Bayford Rd		25a. REC'D BY REGISTRAR S. Rieckert		25b. REGISTRAR'S SIGNATURE Arthur S. Hines									

0354

7582

5

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2828

02810

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY PR. Geog. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b HILLSIDE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 4803 1/2 "M" STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
		HAROLD				ROWE	
4. DATE OF DEATH		Month		Day		Year	
		3		18		1961	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
M		W				6/9/1900	
9. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
60 yrs.		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REPAIRMAN - PIN BALL MACH.				10b. KIND OF BUSINESS OR INDUSTRY ENGLAND			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY? YES U.S.A			
13. FATHER'S NAME HENRY ROWE				14. MOTHER'S MAIDEN NAME MARGARET ALICE DOUTHWAITE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. 004-28-4250			
17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 002X DUE TO UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH SIX MON. (Approx)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3-3- 1961 to 3-18- 1961 , that we (we) lost saw the deceased alive on 3-18- 1961 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/18/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/23/61		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. CEM.		23d. LOCATION (City, town, or county) (State) FORT MYER VA.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS		25a. RECD BY REGISTRAR MAR 24 1961	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2829 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 81 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 1902 CEDRIC ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CLARENCE First Middle Last ROWSON				4. DATE OF DEATH Month Day Year MARCH 18, 19 61				9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 11 1894		11. BIRTHPLACE (County & State, or foreign country) WARWICK CO., VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY ODD JOBS				14. MOTHER'S MAIDEN NAME WINNIE ROWSON			
13. FATHER'S NAME UNKNOWN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or date of service) WW-1				16. SOCIAL SECURITY NO. 219-01-5006			
17. INFORMANT CLIN REC VAH BALTIMORE MD FT HOWARD DIVISION				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, RIGHT LUNG DUE TO Conditions, if any, which gave rise to immediate cause (b) 16 3 X (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 27, 1960 to March 18, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 18, 19 61 , and that death occurred at 7:20 M, from the causes and on the date stated above.											
22a. SIGNATURE Thomas F. Crahan 22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				22b. DATE SIGNED 3/20/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3-22-61				23c. NAME OF CEMETERY OR CREMATORY Baltimore National			
24. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips				ADDRESS 1808 N. Monroe Street Baltimore 17, Maryland				25a. REC'D BY REGISTRAR MAR 23 '61			
								25b. REGISTRAR'S SIGNATURE C. S. Phillips			
23d. LOCATION (City, town or county) Baltimore, Maryland				(State)							

14841

2883



WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

VS. A15ME
5M 7/59

02812

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1606 Thetford Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7501 York Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gary Lee Rozankowski</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>18</u> - Year <u>1961</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-18-1958</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>18</u>	
11. IF UNDER 24 HRS. Hours <u>18</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leon J. Rozankowski</u>		14. MOTHER'S MAIDEN NAME <u>Lorraine Kelbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>same</u>	
17. INFORMANT <u>Leon J. Rozankowski</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Meningitis</u> 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/19/61</u> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-22-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Mem.</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore County, Md.</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck 5305 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

08818

3830 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

M

Robert Thompson

John Smith

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2831

CERTIFICATE OF DEATH

Reg. Dist. No. 02813

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>				c. LENGTH OF STAY IN 1b <u>34 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>736 Peach Cr. Lane</u>				d. STREET ADDRESS <u>1601 Bruce Court</u>			
3. NAME OF DECEASED (Type or print) <u>Lola BEVEN Mac Russell</u>				4. DATE OF DEATH <u>March 22 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 6, 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.		IF UNDER 24 HRS. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private Family</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Andrew MEERS</u>				14. MOTHER'S MAIDEN NAME <u>MARY SNEED</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>217-01-7584</u>		17. INFORMANT <u>Nellie Murphy</u> Address <u>20120t. Hood Ave. Balto 17 Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocard</u> <u>Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>ARTERIO-SCLEROSIS @ BRONCHY HEART Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>14 days</u> <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE 1959</u> to <u>March 22, 1961</u> , that I last saw the deceased alive on <u>MARCH 22, 1961</u> , and that death occurred at <u>7:45 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>William C. Stodo</u> M.D. <u>140 Oak Avenue</u> DATE SIGNED <u>3-22-61</u> PHYSICIAN'S NAME (Type) <u>William C. Wademan</u> <u>DUNDALK 22, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-25-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS PARK</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM A. JACKSON F.H. INC.</u> ADDRESS <u>—</u>				24a. REC'D BY REGISTRAR <u>MAR 28 61</u> DATE <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2832

02814

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 6</u>				c. LENGTH OF STAY IN 1b <u>6</u>											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5435 Radecke Avenue</u>				e. STREET ADDRESS <u>5435 Radecke Avenue</u>											
3. NAME OF DECEASED (Type or print) <u>Mr. George F. Sadofsky</u>				4. DATE OF DEATH <u>March 3, 19 61</u>											
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 19, 1889</u>		9. AGE (In years last birthday) <u>72</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Retail Grocer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>									
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Frank Sadofsky</u>											
14. MOTHER'S MAIDEN NAME <u>Rosa Ziegler</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>											
16. SOCIAL SECURITY NO. <u>212-03-3626A</u>				17. INFORMANT <u>Miss Grayce Sadofsky</u> Address <u>same</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Acute Coronary Thrombosis</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>(1) Peripheral Vascular Disease (2) Post-operative status amputation left leg</u>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>8/4/50</u> to <u>3/3/61</u> , that (I) (we) last saw the deceased alive on <u>Dec 10 19 60</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Julius C. Gluck</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/4/61</u>									
22c. PHYSICIAN'S NAME (Type) <u>Julius C. Gluck, M.D.</u>				22d. ADDRESS <u>5356 Reiskersbarn Road</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road #14</u>				25a. REC'D BY REGISTRAR <u>DATE MAR 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

02819

02819

M

William S.

William S.

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

312-0-10201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2833

CERTIFICATE OF DEATH

02815

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stella Maris Hospice</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>SV01-4</u>	
4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>Sauer</u> Last <u>Sauer</u>		9. AGE (In years last birthday) <u>82</u> yrs.	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/11/1878</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Gallagher</u>		14. MOTHER'S MAIDEN NAME <u>Emma Mc Comas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-03-5024</u>	
17. INFORMANT <u>Admission Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>253X Anoxia</u> DUE TO (b) <u>Exhaust. Bronchopneumonia</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1960</u> to <u>March 1961</u> , that (I) (we) last saw the deceased alive on <u>3/19/1961</u> , and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert J. Mahon</u>		22b. DATE SIGNED <u>2:20 A.M.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Mahon, M.D.</u>		22d. ADDRESS <u>602 E. Joppa Road - Towson, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 20-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Old Frederick Rd. Balto</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Duppel Bros</u>		25a. REC'D BY REGISTRAR <u>7110 Belair Rd.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		DATE <u>MAR 22 '61</u>	

08810

CENTRE OF DEATH

08810

(M)



(M)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **02816**

2834

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 25yr10mth8dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Schenning Last Schenning		4. DATE OF DEATH Month March Day 17 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor		10b. KIND OF BUSINESS OR INDUSTRY restaurant	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Schenning		14. MOTHER'S MAIDEN NAME MARY ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis DUE TO (c) generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes, malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 weeks long standing long standing	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 22, 1961 , to March 17, 1961 , that I last saw the deceased alive on March 17, 1961 , and that death occurred at 6:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 3-17-61	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-20-61	22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM	22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		ADDRESS 9015 CONKLING ST. BALTO., 24, MD.	
24a. REC'D BY REGISTRAR DATE MAR 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2835

CERTIFICATE OF DEATH

Reg. Dist. No. 02817

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. LENGTH OF STAY IN b 9 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2011 Oak Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cecelia B. Schmitt		4. DATE OF DEATH Month March Day 25 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George N. A. Schmitt		14. MOTHER'S MAIDEN NAME Katherine M. Ludwig	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-14-4649	
17. INFORMANT Miss Dorothy H. Ludwig		Address 115 Rosewood Ave. (28)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7-2 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 3/19/56 , 19____, to 2/20/61 , 19____, that I last saw the deceased alive on 4/20/61 , 19____, and that death occurred at 6 PM , from the causes and on the date stated above.	
ACTUAL SIGNATURE Milton Schleuoff		ADDRESS (Street, city or town, state) 6410 Windsor Mill Rd Baltimore Md.	
PHYSICIAN'S NAME (Type) Milton Schleuoff		DATE SIGNED 3/28/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-1961	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong		ADDRESS 3207 W North Ave	
24a. REC'D BY REGISTRAR DATE MAR 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1832

1832

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF DEATH</p>	
<p>5. PLACE OF DEATH</p>		<p>6. CAUSE OF DEATH</p>	
<p>7. OCCASION OF DEATH</p>		<p>8. SIGNATURE OF PHYSICIAN</p>	
<p>9. SIGNATURE OF WITNESSES</p>		<p>10. SIGNATURE OF REGISTRAR</p>	
<p>11. SIGNATURE OF CLERK</p>		<p>12. SIGNATURE OF DEPUTY CLERK</p>	
<p>13. SIGNATURE OF ASSISTANT CLERK</p>		<p>14. SIGNATURE OF CHIEF CLERK</p>	
<p>15. SIGNATURE OF DEPUTY CHIEF CLERK</p>		<p>16. SIGNATURE OF ASSISTANT DEPUTY CHIEF CLERK</p>	
<p>17. SIGNATURE OF CLERK IN CHARGE</p>		<p>18. SIGNATURE OF CLERK IN CHARGE</p>	
<p>19. SIGNATURE OF CLERK IN CHARGE</p>		<p>20. SIGNATURE OF CLERK IN CHARGE</p>	
<p>21. SIGNATURE OF CLERK IN CHARGE</p>		<p>22. SIGNATURE OF CLERK IN CHARGE</p>	
<p>23. SIGNATURE OF CLERK IN CHARGE</p>		<p>24. SIGNATURE OF CLERK IN CHARGE</p>	
<p>25. SIGNATURE OF CLERK IN CHARGE</p>		<p>26. SIGNATURE OF CLERK IN CHARGE</p>	
<p>27. SIGNATURE OF CLERK IN CHARGE</p>		<p>28. SIGNATURE OF CLERK IN CHARGE</p>	
<p>29. SIGNATURE OF CLERK IN CHARGE</p>		<p>30. SIGNATURE OF CLERK IN CHARGE</p>	
<p>31. SIGNATURE OF CLERK IN CHARGE</p>		<p>32. SIGNATURE OF CLERK IN CHARGE</p>	
<p>33. SIGNATURE OF CLERK IN CHARGE</p>		<p>34. SIGNATURE OF CLERK IN CHARGE</p>	
<p>35. SIGNATURE OF CLERK IN CHARGE</p>		<p>36. SIGNATURE OF CLERK IN CHARGE</p>	
<p>37. SIGNATURE OF CLERK IN CHARGE</p>		<p>38. SIGNATURE OF CLERK IN CHARGE</p>	
<p>39. SIGNATURE OF CLERK IN CHARGE</p>		<p>40. SIGNATURE OF CLERK IN CHARGE</p>	
<p>41. SIGNATURE OF CLERK IN CHARGE</p>		<p>42. SIGNATURE OF CLERK IN CHARGE</p>	
<p>43. SIGNATURE OF CLERK IN CHARGE</p>		<p>44. SIGNATURE OF CLERK IN CHARGE</p>	
<p>45. SIGNATURE OF CLERK IN CHARGE</p>		<p>46. SIGNATURE OF CLERK IN CHARGE</p>	
<p>47. SIGNATURE OF CLERK IN CHARGE</p>		<p>48. SIGNATURE OF CLERK IN CHARGE</p>	
<p>49. SIGNATURE OF CLERK IN CHARGE</p>		<p>50. SIGNATURE OF CLERK IN CHARGE</p>	
<p>51. SIGNATURE OF CLERK IN CHARGE</p>		<p>52. SIGNATURE OF CLERK IN CHARGE</p>	
<p>53. SIGNATURE OF CLERK IN CHARGE</p>		<p>54. SIGNATURE OF CLERK IN CHARGE</p>	
<p>55. SIGNATURE OF CLERK IN CHARGE</p>		<p>56. SIGNATURE OF CLERK IN CHARGE</p>	
<p>57. SIGNATURE OF CLERK IN CHARGE</p>		<p>58. SIGNATURE OF CLERK IN CHARGE</p>	
<p>59. SIGNATURE OF CLERK IN CHARGE</p>		<p>60. SIGNATURE OF CLERK IN CHARGE</p>	
<p>61. SIGNATURE OF CLERK IN CHARGE</p>		<p>62. SIGNATURE OF CLERK IN CHARGE</p>	
<p>63. SIGNATURE OF CLERK IN CHARGE</p>		<p>64. SIGNATURE OF CLERK IN CHARGE</p>	
<p>65. SIGNATURE OF CLERK IN CHARGE</p>		<p>66. SIGNATURE OF CLERK IN CHARGE</p>	
<p>67. SIGNATURE OF CLERK IN CHARGE</p>		<p>68. SIGNATURE OF CLERK IN CHARGE</p>	
<p>69. SIGNATURE OF CLERK IN CHARGE</p>		<p>70. SIGNATURE OF CLERK IN CHARGE</p>	
<p>71. SIGNATURE OF CLERK IN CHARGE</p>		<p>72. SIGNATURE OF CLERK IN CHARGE</p>	
<p>73. SIGNATURE OF CLERK IN CHARGE</p>		<p>74. SIGNATURE OF CLERK IN CHARGE</p>	
<p>75. SIGNATURE OF CLERK IN CHARGE</p>		<p>76. SIGNATURE OF CLERK IN CHARGE</p>	
<p>77. SIGNATURE OF CLERK IN CHARGE</p>		<p>78. SIGNATURE OF CLERK IN CHARGE</p>	
<p>79. SIGNATURE OF CLERK IN CHARGE</p>		<p>80. SIGNATURE OF CLERK IN CHARGE</p>	
<p>81. SIGNATURE OF CLERK IN CHARGE</p>		<p>82. SIGNATURE OF CLERK IN CHARGE</p>	
<p>83. SIGNATURE OF CLERK IN CHARGE</p>		<p>84. SIGNATURE OF CLERK IN CHARGE</p>	
<p>85. SIGNATURE OF CLERK IN CHARGE</p>		<p>86. SIGNATURE OF CLERK IN CHARGE</p>	
<p>87. SIGNATURE OF CLERK IN CHARGE</p>		<p>88. SIGNATURE OF CLERK IN CHARGE</p>	
<p>89. SIGNATURE OF CLERK IN CHARGE</p>		<p>90. SIGNATURE OF CLERK IN CHARGE</p>	
<p>91. SIGNATURE OF CLERK IN CHARGE</p>		<p>92. SIGNATURE OF CLERK IN CHARGE</p>	
<p>93. SIGNATURE OF CLERK IN CHARGE</p>		<p>94. SIGNATURE OF CLERK IN CHARGE</p>	
<p>95. SIGNATURE OF CLERK IN CHARGE</p>		<p>96. SIGNATURE OF CLERK IN CHARGE</p>	
<p>97. SIGNATURE OF CLERK IN CHARGE</p>		<p>98. SIGNATURE OF CLERK IN CHARGE</p>	
<p>99. SIGNATURE OF CLERK IN CHARGE</p>		<p>100. SIGNATURE OF CLERK IN CHARGE</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2836

CERTIFICATE OF DEATH

Reg. Dist. No. 02818

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b X Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5309 XXXX Lewellen Avenue				e. STREET ADDRESS 5309 Lewellen Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY ANGELA SCHMITT				4. DATE OF DEATH Month Day Year March 6 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1896	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Nesor				14. MOTHER'S MAIDEN NAME Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Louis R. Schmitt=5309 Lewellen Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 1 hour 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) *****				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****			
20c. TIME OF INJURY Month, Day, Year Haven't happened p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 59 , to March , 19 61 , that I last saw the deceased alive on March 6 , 19 61 , and that death occurred at 1:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5101 Gwynn Oak Avenue - 7 - DATE SIGNED 3/7/61 ACTUAL SIGNATURE Millard T. Traband, Jr. M.D. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr., M.D. 5101 Gwynn Oak Avenue - 7 -							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/1961		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.				24a. REC'D BY REGISTRAR MAR 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08818

CERTIFICATE OF DEATH

2838

Belmont

1st Ward

Belmont

Woodlawn

5401 Jewell Avenue

12100 Jewell Avenue

March

MARY ANGELA SCHMIDT

64

Sept. 13, 1896

White

Female

USA

Baltimore, Maryland

At his residence

John Smith

John Smith

John B. Schmidt, 5300 Jewell Avenue

None

1 hour

General Condition

2 years

Autopsy performed by Dr. J. B. Schmidt

61

March

1904

January

61

March

1/1/01

3101 Owens Gap Avenue - 1 -

3101 Owens Gap Avenue, D. C.

Baltimore, Maryland

New Cathedral Cemetery

11400 Armatrust-5000 Liberty Road, Ave.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2837

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN 1b <i>10 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Angsburg Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>50PHIA</i> Middle <i>SCHNEIDER</i> Last <i>SCHNEIDER</i>		4. DATE OF DEATH Month <i>March</i> Day <i>13</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 28, 1872</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Household</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>
13. FATHER'S NAME <i>Louis Schneider</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Eck</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>5-1-1-1-1-1-1-1-1-1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0 Anterio-sclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>420.0</i> DUE TO (c) <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized Arterio-sclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 13</i> , 19 <i>61</i> , to <i>4:35 P.</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>March 13</i> , 19 <i>61</i> , and that death occurred at <i>4:35 P.</i> , M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Earl L. Chambers</i>		DATE SIGNED <i>3/13/61</i>	
PHYSICIAN'S NAME (Type) <i>Earl L. Chambers</i>		ADDRESS (Street, city or town, state) <i>4108 Liberty Hts. Balt. Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/16/61</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Matthew</i>		22d. LOCATION (City, town, or county) (State) <i>Cremell St</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Heulth Neumann</i>		ADDRESS <i>Hay Rd</i>	
24a. REC'D BY REGISTRAR <i>MAR 16 61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Moore</i>	

M

I

0

0

2837



Johnson

[Faint, illegible handwritten text, possibly a signature or address]

[Faint, illegible handwritten text, possibly a signature or address]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02820

2838

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>125 Forrest Ave.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>125 Forrest Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William J. Schreiber</u> First Middle Last				4. DATE OF DEATH <u>March 13 1961</u> Month Day Year											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 19-1873</u>		9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Const.</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>William Schreiber</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mrs. Richard Mossop</u>				Address <u>125 Forrest Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>old decompensation</u> (b) <u>Cancer of prostate</u> DUE TO <u>7 yrs</u> (c) <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>3 mo 5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>19 58</u> , 19 <u>58</u> , to <u>March 1961</u> , that I last saw the deceased alive on <u>March 12, 1961</u> , and that death occurred at <u>7:25</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5609 Main St</u> DATE SIGNED															
ACTUAL SIGNATURE <u>B B Brumbaugh M.D.</u>															
PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/16/61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>				22d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Nippert</u> ADDRESS <u>1300 Eutaw Pl.</u>															
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Carl S. Kline</u>				DATE <u>16 '61</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

1933

FILE NO.

PLACED IN

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DIVORCE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

NAME OF PREVIOUS SPOUSE

DATE OF PREVIOUS MARRIAGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2845

CERTIFICATE OF DEATH

02821

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 29yr7mth7days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 4205 Woodstock Avenue			
3. NAME OF DECEASED (Type or print) First Paul Middle Smith Last Senner				4. DATE OF DEATH Month March Day 10 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 7, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 78 Days 78		IF UNDER 24 HRS. Hours 78 Min. 78			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sheet metal worker				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John D. Smith				14. MOTHER'S MAIDEN NAME Susal Killian			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) unknown				16. SOCIAL SECURITY NO. unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic lesion of lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 165X DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 5, 1961 to March 10, 1961 , that (I) (we) last saw the deceased alive on March 10, 1961 , and that death occurred at 8:09 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler				22b. DATE SIGNED 3-10-61			
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3-29-61		23c. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery Baltimore, Md.		23d. LOCATION (City, town or county) (State)	
24 FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus				25a. RECEIVED BY REGISTRAR APR 3 '61			
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

158851

RECEIVED

158851

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2839

CERTIFICATE OF DEATH

02823

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 76 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Annes c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville d. STREET ADDRESS 310 S. Commerce Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN M. SHAW				4. DATE OF DEATH March 16 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) 67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobile Agency		11. BIRTHPLACE (County & State, or foreign country) Cordova, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Shaw				14. MOTHER'S MAIDEN NAME Eliza J. Towers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 217-05-3717			
17. INFORMANT Clinical Records, VAH, BALTIMORE 18, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (b) PULMONARY EMPHYSEMA, MARKED (c) POST-OPERATIVE STATE-NEPHRECTOMY FOR CARCINOMA, KIDNEY cause last. RECENT			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Cerebral Thrombosis (Clinical). Carcinoma Thyroid with Metastases to Superior Mediastinum.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (he) (this hospital) attended the deceased from December 30, 1960 , to March 16, 1961 , that (he) (we) last saw the deceased alive on March 16, 1961 , and that death occurred at 8:50 AM , from the causes and on the date stated above.		22a. SIGNATURE Thomas F. Crahan M.D. 22b. DATE SIGNED 3/16/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF MARCH 18 1961	
23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION (City, town or county) (State) Centreville, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE Barton Brothers Funeral Home		25a. REC'D BY REGISTRAR MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE MAR 21 '61		25d. REGISTRAR'S SIGNATURE Arthur S. Kraus		25e. DATE MAR 21 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

3839

M

I

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2840

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02824

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Halethorpe				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Sipple Last 				4. DATE OF DEATH Month March Day 5 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 28, 1874	
9. AGE (In years lost birthday) 86 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Sipple				14. MOTHER'S MAIDEN NAME Laura Easley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Mrs Alice G. Sipple				Address 1256 Francis Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 1 wk 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1961 to March 5, 1961 , that (I) (we) last saw the deceased alive on March 4, 1961 , and that death occurred at 4:30 M., from the causes and on the date stated above.							
22a. SIGNATURE A Bradley Daugharthy				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-5-61	
22c. PHYSICIAN'S NAME (Type) 1264 Francis Avenue Balto. 27, Md.				22d. ADDRESS A. Bradley Daugharthy, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-7-1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City, town, or county) (State) North Ave Balto Md	
24. FUNERAL DIRECTOR'S SIGNATURE Leo G. Cook & Son 1701-03 Patterson Pk.				25a. REC'D BY REGISTRAR MAR 8 '61		25b. REGISTRAR'S SIGNATURE Arthur L. K...	

I

C

1961

43850

1
VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2841

CERTIFICATE OF DEATH

Reg. Dist. No.

02711

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		d. STREET ADDRESS Glenarm Road	
3. NAME OF DECEASED (Type or print) Sister Mary Expedita Frey		4. DATE OF DEATH March 6 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1873
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) Milford Township, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Frey		14. MOTHER'S MAIDEN NAME Josephine Steingruber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Generalized arterio- sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 mos. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1952 , to March 1961 , that I last saw the deceased alive on March 2, 1961 , and that death occurred at 10:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Road Towson 4, Md. DATE SIGNED 3/6/61			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-8-61	
22c. NAME OF CEMETERY OR CREMATORY VILLA MARIA CEM.		22d. LOCATION (City, town, or county) (State) NOTCH CLIFF NR TOWSON, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Zeller		ADDRESS 901 S. CONKLING ST.	
24a. REC'D BY REGISTRAR MAR 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

CERTIFICATE OF DEATH

2023

0823

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1950-01-01</u></p>		<p>4. Place of birth: <u>USA</u></p>	
<p>5. Date of death: <u>2023-01-01</u></p>		<p>6. Place of death: <u>Home</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>2023-01-01</u></p>		<p>12. Office of registration: <u>Baltimore</u></p>	



THIS CERTIFICATE IS REQUIRED BY LAW TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND TO BE MADE AVAILABLE TO THE PUBLIC. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THE RECORDS AND TO FURNISH COPIES OF THE SAME TO THE REQUESTING PARTY.

Reg. Dist. No. 02825

CERTIFICATE OF DEATH

Reg. Dist. No. 02825

1. PLACE OF DEATH o. COUNTY <u>Balto</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN lb <u>2 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4508 Springwood Ave</u>		d. STREET ADDRESS <u>14508 Springwood Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stetania</u> Middle <u>Slowakiewicz</u> Last <u></u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15 1886</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
13. FATHER'S NAME <u>John Slawinski</u>		14. MOTHER'S MAIDEN NAME <u>Rodulfa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Walter Slowakiewicz</u> Address <u>4508 Springwood</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, acute</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral stenosis and insufficiency. Paralytic ileus</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>		20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>2-16</u> , 19 <u>61</u> , to <u>3-12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-16</u> , 19 <u>61</u> , and that death occurred at <u>8:34 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6801 Belair Rd, Balto. 6 Md</u> DATE SIGNED <u>3-13-61</u>					
ACTUAL SIGNATURE <u>Santi Amoroso</u>		M.D. <u>6801 BELAIR RD BALTO 6 MD</u>			
PHYSICIAN'S NAME (Type) <u>SANTI AMOROSO</u>		<u>6801 BELAIR RD BALTO 6 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-15-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary Cem</u>	
22d. LOCATION (City, town, or county) <u>German Hill Rd, Balto, Md</u>		22e. (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Prinzel Bros. 7110 Robin Rd.</u>		ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>MAR 14 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>					

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2843

CERTIFICATE OF DEATH

Reg. Dist. No. 02827

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>		c. LENGTH OF STAY IN 1b <u>60 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Turners Station</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>118 Walnut Avenue</u>				d. STREET ADDRESS <u>118 Walnut Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Dunival</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1961</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/13/87</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Drakesbranch, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Nathaniel Dunival</u>			14. MOTHER'S MAIDEN NAME <u>Lucretia-Jones</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Ruth Law</u> Address <u>118 Walnut Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>570.5</u> DUE TO <u>Intestinal Obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>obesity</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <u> </u> at work <input type="checkbox"/> Not while <u> </u> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>March 24-61</u> to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>March 29-61</u> , and that death occurred at <u>5A</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>107 N. Main St. Balt 22</u> DATE SIGNED <u>3/30/61</u>							
ACTUAL SIGNATURE <u>Dr. Thomas</u>		M.D. <u>107 N. Main St. Balt 22</u>					
PHYSICIAN'S NAME (Type) <u>Dr. Thomas M.D.</u>		<u>Balt 22 3/30/61</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/1/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Arbutus, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Johnson</u>				ADDRESS <u>1011-13 N. Arlington Ave</u>		24a. REC'D BY REGISTRAR <u>APR 6 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2844

CERTIFICATE OF DEATH

02826

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>	
c. LENGTH OF STAY IN <u>Life</u>		d. STREET ADDRESS <u>1219 Falls Rd.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Big Falls Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Geo. I. Smith</u>		4. DATE OF DEATH <u>3/3/61</u> 19 <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1891</u>
9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sec. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-9581</u>	
17. INFORMANT <u>Edith Johnson - Big Falls Rd. Hereford, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO <u>Arterio Sclerotic Cardio Vascular Disease</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hr</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1961</u> to <u>March 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 2, 1961</u> , and that death occurred at <u>3:13/4/61 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>C. Herbert Mueller Jr</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER JR</u>		22d. ADDRESS <u>PARKTON - MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>3/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes</u>		23d. LOCATION (City, town, or county) (State) <u>Hereford, Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Chaturang - 1701 Mt. Cuthbert St. Balto. Md.</u>		25a. REC'D BY REGISTRAR <u>DATE MAR 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

3844

CERTIFICATE OF DEATH

US 384

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Discernible fragments include:]

... of ...
... born ...
... died ...
... cause of death ...
... place of death ...
... physician ...
... funeral home ...
... date of death ...
... place of birth ...
... date of birth ...
... sex ...
... race ...
... occupation ...
... marital status ...
... education ...
... religion ...
... social security number ...
... signature ...
... date ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
2846											
02828											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 74 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 308 Grovethorne Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) RICHARD R. SMITH					4. DATE OF DEATH MARCH 18 19 61						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/14/21		9. AGE (In years last birthday) 39 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man					10b. KIND OF BUSINESS OR INDUSTRY Martin Co.		11. BIRTHPLACE (County & State, or foreign country) Natrona Heights, Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edmund Smith					14. MOTHER'S MAIDEN NAME Ava Faulkner						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW II					16. SOCIAL SECURITY NO. 171-14-8271					17. INFORMANT Clin. Rec. VAH, Balto. Md. Fort Howard Division Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (b) CARCINOMA RIGHT LUNG WITH WIDE SPREAD METASTASES DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 48 HOURS UNKNOWN		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Jan. 3 1961 to March 18 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 18 1961 , and that death occurred at 5:50 PM from the causes and on the date stated above.											
22a. SIGNATURE Paul G. Koukoulas					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/18/61				
22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS, M.D.					22d. ADDRESS VAH, Balto. Md. Fort Howard Division						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 22, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt Airy Cemetery		23d. LOCATION (City, town or county) (State) Natrona Heights, Pennsylvania					
24. FUNERAL DIRECTOR'S SIGNATURE Ferver Funeral Home ADDRESS Tarentum, Penn.					25a. REC'D BY REGISTRAR MARCH 22, 1961 DATE		25b. REGISTRAR'S SIGNATURE Arthur S. Kline				

MAR 20 '61

AS250

363

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2847

CERTIFICATE OF DEATH

02829

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4946 Tulip Avenue				e. STREET ADDRESS 4946 Tulip Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle C. Last Smith, Sr.				4. DATE OF DEATH Month March Day 27 Year 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1891	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Westinghouse		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Smith				14. MOTHER'S MAIDEN NAME Kate McGill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] no [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 034 07 4192		17. INFORMANT Address Relay 27, Md. Mrs. Isabella Smith 4946 Tulip Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration - refusal to eat or drink 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General debility - following pneumonia DUE TO (c) Per cardiac arrest							INTERVAL BETWEEN ONSET AND DEATH 4 hrs 20 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Relay	(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1961 to March 25, 1961 , that (I) (we) last saw the deceased alive on March 19, 1961 , and that death occurred at 2:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Frederick Beitler		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Frederick Beitler, M. D.		22d. ADDRESS 1014 Francis Avenue, #27					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/29/61	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City, town, or county) (State) Elkridge, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR DATE MAR 30 '61	25b. REGISTRAR'S SIGNATURE Charles E. Howard		

1882

DATE OF BIRTH

1882

NO. 100

NAME

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

WILLIAM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2848

Reg. Dist. No. 02830

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>301-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dundalk YMA</u>		e. STREET ADDRESS <u>2807 Inglewood Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>A. Jeanne Spittel</u>		4. DATE OF DEATH <u>March 15 1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 8, 1925</u>
9. AGE (In years last birthday) <u>36</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dictaphone Transcriber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hopkins</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry O. Spittel</u>		14. MOTHER'S MAIDEN NAME <u>Alice M. Wickes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>220224532</u>	
17. INFORMANT <u>Henry O. Spittel</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound (Pistol) Thru Rt. Parietal Region</u></p> <p>976X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (b) <u> </u></p> <p>(c), stating the underlying cause last. DUE TO (c) <u> </u></p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u> </u></p> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot Self Thru Rt. Temple</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:30 p.m. 3-15-1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>YMA</u>		20f. City or town (County) (State) <u>Dundalk-Balto. Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/15/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-18-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Rd.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 17 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. Includes checkboxes for various conditions and a large area for the examiner's signature and notes.

12-20-21

12-20-21

12-20-21

12-20-21

12-20-21

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2849

02831

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 17 Joppa Rd.				d. STREET ADDRESS Box 17 Joppa Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Emanuel Middle A. Last Stastny				4. DATE OF DEATH Month March Day 16 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Nov. 4, 1890	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-Retired				10b. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Frank Stastny				14. MOTHER'S MAIDEN NAME Marie Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-07-4228		17. INFORMANT Mrs. Rosalie M. Stastny Address Fullerton, Md Box 17 Joppa Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular renal. disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH 17 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1944 to Mar. 16 1961 , that (I) (we) last saw the deceased alive on Feb. 23 1961 , and that death occurred 1:30 P. from the causes and on the date stated above.							
22a. SIGNATURE G. M. Bacon				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/17/61	
22c. PHYSICIAN'S NAME (Type) A.M. BACON				22d. ADDRESS 2810 Taylor Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3-18-1961		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd.		25a. REC'D BY REGISTRAR DATE MAR 20 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

MEDICAL CERTIFICATION

11203

2025

11

Carroll - 12/10/1914

11203

11203

11203

A.M. BACON

11203

TO HOSTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the law requires that the death certificate be executed within 24 hours after death, the law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2850 CERTIFICATE OF DEATH 02832											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard						c. LENGTH OF STAY IN lb 22 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						e. STREET ADDRESS 1017 Madison Street					
3. NAME OF DECEASED (Type or print) First WALTER Middle - - Last STEIN						4. DATE OF DEATH Month March Day 11 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1900		9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman				10b. KIND OF BUSINESS OR INDUSTRY Highway				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stein						14. MOTHER'S MAIDEN NAME Victoria - Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-11						16. SOCIAL SECURITY NO. 218-05-9694					
17. INFORMANT Clin. Records						Address VA Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 1 year					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 17 1961 to Mar. 11 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 11 1961 , and that death occurred at 1:45 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Joshua A. Smith						M.D. JOSHUA A. SMITH, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/11/61	
22c. PHYSICIAN'S NAME (Type) JOSHUA A. SMITH, M.D.						22d. ADDRESS 3900 Loch Raven Blvd. VAH, Baltimore 18, Md. Fort Howard Div.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF 3-15-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Funeral Home						25a. REC'D BY REGISTRAR 6009 Harford Rd. Baltimore, Md.		25b. REGISTRAR'S SIGNATURE DATE MAR 15 '61		25c. REGISTRAR'S SIGNATURE Arthur S. Kline	

2595

1720

14-00000

Mr. Cook-11th June 1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
4
2851
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02833

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN PINES, 16 FUSTING AVE.		d. STREET ADDRESS 4600 MANORDENE RD.	
3. NAME OF DECEASED (Type or print) LUDWIG CARL STEINHAGEN		4. DATE OF DEATH MAR. 16, 1961	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 5, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED TRAFFIC ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY BALTO. TRANSIT	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEINHAGEN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS ETHEL K. STEINHAGEN		Address 4600 MANORDENE RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Decomposition 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hypertensive-Cardio-Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks 10/31	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-23, 1961 to 3-16, 1961 , that (I) (we) last saw the deceased alive on 3-16, 1961 , and that death occurred at 4:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE SIGNED 3-17-61	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D.		22d. ADDRESS 6207 Frederick Ave. Balt. 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/20/61	
23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMT.		23d. LOCATION (City, town, or county) (State) PIKESVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F.D.		25a. REC'D BY REGISTRAR MAR 20 '61	
ADDRESS 4101 EDMONDSON AVE.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

36831

4128



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2852

CERTIFICATE OF DEATH

Reg. Dist. No. 02834

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stoneleigh</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>812 Register Ave. (Arumcort)</u>		d. STREET ADDRESS <u>12X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Lily</u> Middle <u>Patterson</u> Last <u>Stier</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14th</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30-1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick Ethelred Patterson</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Plaggett Powell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Arumcort Nursing Home 812 Register Ave.</u>	
17. INFORMANT Address <u>Baltimore</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ArterioSclerotic Cordic Renal Vascular Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>18 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>56</u> , to <u>March 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 14</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) <u>7501 York Rd</u> DATE SIGNED <u>3/15/61</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>		<u>Johnson #4 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/18/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Perryman Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Sarring - Aberdeen, Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 22 1961</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

POST

18234

<p>1. NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>2. SEX</p> <p><i>Male</i></p>		<p>3. AGE</p> <p><i>45</i></p>	
<p>4. DATE OF DEATH</p> <p><i>Jan 15 1924</i></p>		<p>5. TIME OF DEATH</p> <p><i>10:30 AM</i></p>		<p>6. PLACE OF DEATH</p> <p><i>Home</i></p>	
<p>7. CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>		<p>8. DISEASE OR INJURY</p> <p><i>Myocardial Infarction</i></p>		<p>9. MANNER OF DEATH</p> <p><i>Natural</i></p>	
<p>10. SIGNATURE OF PHYSICIAN</p> <p><i>John Doe</i></p>		<p>11. SIGNATURE OF REGISTRAR</p> <p><i>John Doe</i></p>		<p>12. SIGNATURE OF WITNESSES</p> <p><i>John Doe</i></p>	

M

TO BE FILLED BY THE REGISTRAR

1. DATE OF DEATH

2. TIME OF DEATH

3. PLACE OF DEATH

4. CAUSE OF DEATH

5. DISEASE OR INJURY

6. MANNER OF DEATH

7. SIGNATURE OF PHYSICIAN

8. SIGNATURE OF REGISTRAR

9. SIGNATURE OF WITNESSES

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2853
CERTIFICATE OF DEATH

02835

PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>Pyrrldys</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>George</u> Last <u>Stitt</u>		4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1880</u>
9. AGE (In years last birthday) <u>80s.</u>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sylvester Stitt</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Nofsker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pleural effusion and pulmonary edema</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease with hypertension</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1959</u> , to <u>March 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>March 21, 19 61</u> , and that death occurred at <u>1:00</u> M, from the causes and on the date stated above.			
22e. SIGNATURE <u>Stella Wachsler</u> M.D.		22b. DATE SIGNED <u>3-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/25/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Blairsville Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Blairsville Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Davis</u>		25a. REC'D BY REGISTRAR <u>MAR 23 '61</u>	
ADDRESS <u>Catonsville, Md</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	

VR A15 (4)
15M 9/60

28850

1223

11

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

2854

02836

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PARADISE NURSING HOME				e. STREET ADDRESS 1 132 NUNNERY LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LULA E. STYRON				4. DATE OF DEATH Month Day Year MARCH 11 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 20, 1874		9. AGE (In years last birthday) yrs. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN EASTWOOD				14. MOTHER'S MAIDEN NAME ELEANOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address Joseph Styron - 132 Nunnery Lane			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) arteriosclerotic cardiovascular disease DUE TO — (c) —						INTERVAL BETWEEN ONSET AND DEATH 2 hrs 20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Sept. 1957 to 11 March 1961 , that (I) (we) last saw the deceased alive on 10 March 1961 , and that death occurred at 6P M, from the causes and on the date stated above.							
22a. SIGNATURE James E. Rowe				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 14 Mar 61	
22c. PHYSICIAN'S NAME (Type) James E. Rowe, M. D.				22d. ADDRESS 1011 Frederick Rd. Baltimore 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-15-61		23c. NAME OF CEMETERY OR CREMATORY Trueman Park Cem.		23d. LOCATION (City, town, or county) (State) Bald. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Foley-Corrough F.H. - Catonsville, Md.				25a. REC'D BY REGISTRAR —		25b. REGISTRAR'S SIGNATURE Charles S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

65850

CERTIFICATE OF DEATH

65850



[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]



CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
2855
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore LaPlata	
3. NAME OF DECEASED (Type or print) Joshua SWANN		4. DATE OF DEATH Month March Day 4 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23 1883
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mary Mattingly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. 220-348435	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Cerebral and Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 33 IX DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/6/61 to 3/4/61 19 61 , that (I) (we) last saw the deceased alive on 3/4/61 19 61 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Patrick Ki-Yun Yip		22b. DATE SIGNED MAR 5 1961	
22c. PHYSICIAN'S NAME (Type) PATRICK Ki-Yun Yip		22d. ADDRESS SPRING GROVE STATE HOSPITAL BALTIMORE 28 MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/7/61	
23c. NAME OF CEMETERY OR CREMATORY NOT Rest Cem.		23d. LOCATION (City, town or county) (State) LA PLATA MD	
24. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf Md.		25a. REC'D BY REGISTRAR MAR 10 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

08231

2338

I

Patrick K. Ryan (1911)
Patrick K. Ryan (1911)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2856 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
2856
Item 23 d, film G285
3/24/61 iwr
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

02838

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Byway Road		d. STREET ADDRESS 15 Byway Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Long Talbert		4. DATE OF DEATH Month 3 - Day 16 - Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1884
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Long		14. MOTHER'S MAIDEN NAME Minnie Rannader	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Robert L. Talbert		Address Owings Mills 15 Byway Rd. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis Arteriosclerotic C-V Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 42241 (c) none DUE TO (b) none (c) none INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that (I) which hospital attended the deceased from 12-26-39 19 to 3-16-61 19, that (I) xxx last saw the deceased alive on 3-16-61 19, and that death occurred at 10:30AM M, from the causes and on the date stated above.			
22a. SIGNATURE D. D. Caples		22b. DATE SIGNED 3-18-61	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.		22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-61	
23c. NAME OF CEMETERY OR CREMATORY Grace Methodist		23d. LOCATION (City, town, or county) (State) Cockeysville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Br		25a. REC'D BY REGISTRAR DATE MAR 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

4833

OFFICE OF THE SECRETARY OF DEFENSE

2550

(M)

(1)

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02839

2857

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN TB 43 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 229 Patapsco Avenue				d. STREET ADDRESS 229 Patapsco Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LIA Middle LOUISE Last TAMASSIA				4. DATE OF DEATH Month March Day 22nd , Year 1961			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? Italy ✓							
13. FATHER'S NAME Peter Rossi				14. MOTHER'S MAIDEN NAME ??? Bertazza			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address H.V. Tamassia, 30 Bangert Ave., Fullerton	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension Cardiovascular Disease DUE TO (c) 10 years							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-7-1951 to 3-22-1961 , that I last saw the deceased alive on 3-22-1961 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Morningson Road DATE SIGNED 3/24/61							
ACTUAL SIGNATURE Eugene F. Navy				M.D. 7001 Morningson Road			
PHYSICIAN'S NAME (Type) Eugene Navy, M.D.				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/61		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk, Md.				24a. REC'D BY REGISTRAR DATE MAR 27 '61		24b. REGISTRAR'S SIGNATURE Anthony S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02883

NAME OF DECEASED Daniel J. (1931)		SEX Male	
DATE OF BIRTH 07-08-1902		PLACE OF BIRTH Baltimore, Maryland	
220 Patterson Avenue		220 Patterson Avenue	
CITY OF BALTIMORE, MARYLAND		COUNTY OF BALTIMORE, MARYLAND	
DECEASED'S RESIDENCE 220 Patterson Avenue, Baltimore, Maryland		DECEASED'S OCCUPATION None	
DATE OF DEATH July 21, 1962		PLACE OF DEATH Home	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH Myocardial Infarction	
MEDICAL HISTORY None		HISTORY OF PRESENT ILLNESS None	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF WITNESS [Signature]	
NAME OF PHYSICIAN [Name]		NAME OF WITNESS [Name]	
ADDRESS OF PHYSICIAN [Address]		ADDRESS OF WITNESS [Address]	
CITY OF PHYSICIAN Baltimore, Maryland		CITY OF WITNESS Baltimore, Maryland	
STATE OF PHYSICIAN Maryland		STATE OF WITNESS Maryland	
DATE OF DEATH July 21, 1962		TIME OF DEATH 10:00 AM	
PLACE OF DEATH Home		CAUSE OF DEATH Myocardial Infarction	
MEDICAL HISTORY None		HISTORY OF PRESENT ILLNESS None	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF WITNESS [Signature]	
NAME OF PHYSICIAN [Name]		NAME OF WITNESS [Name]	
ADDRESS OF PHYSICIAN [Address]		ADDRESS OF WITNESS [Address]	
CITY OF PHYSICIAN Baltimore, Maryland		CITY OF WITNESS Baltimore, Maryland	
STATE OF PHYSICIAN Maryland		STATE OF WITNESS Maryland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2858
CERTIFICATE OF DEATH

02840

1. PLACE OF DEATH e. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. 12		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTO. 12			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 524 CASTLE DRIVE				d. STREET ADDRESS 524 CASTLE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle V. Last TATUM				4. DATE OF DEATH Month MARCH Day 30 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 27, 1871		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL HOLMES				14. MOTHER'S MAIDEN NAME HANNA LAIFF			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT MRS. DOROTHY T. HERRLICH		Address ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENCEPHALOMALACIA 332X DUE TO Conditions, if any, which gave rise to immediate cause (b) GENERALIZED ARTERIOSCLEROSIS (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH 2 yr. 10 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE , 19 59 , to MAR. 30 19 61 , that (I) (we) last saw the deceased alive on MAR. 19, 1961 , and that death occurred at 10 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE <i>Frederick J. Vollmer</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED MAR. 31, 1961	
22c. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER				22d. ADDRESS 6100 YORK RD, BALTO. 12 MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-3-61		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL		23d. LOCATION (City, town or county) (State) BALTO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS CO. 4905 YORK ROAD				25a. REC'D BY REGISTRAR APR 3 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

00330

2222

(M)

(1)

How does your life look now?

It's a new chapter.

Goodbye

1991

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2859

CERTIFICATE OF DEATH

02841

Items 13 & 14 Film G284 4/5/61

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House In Pines, 16 Fusting Ave.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5105 Edmondson Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John J. Tatum		4. DATE OF DEATH Month Day Year March 28/61 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1866 9. AGE (In years last birthday) 94 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Balto. Md. 12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Tatum unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Chauncey R. Tatum, 5105 Edmondson Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO (b) Arteriosclerotic cardio vascular disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 11, 1943 to March 28, 1961 , that (I) (we) last saw the deceased alive on March 28, 1961 , and that death occurred 2:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George A. Knipp 22c. PHYSICIAN'S NAME (Type) George A. Knipp, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Mar. 29, 1961 22d. ADDRESS 4116 Edmondson Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/30/61	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City, town or county) (State) Baltimore 29, Md.
24 FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.		25a. REC'D BY REGISTRAR 4101 Edmondson Ave DATE MAR 30 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Baltimore

Catonsville

House in fire, 18 Waring Ave.

6105 Edmonson Ave

March 28/61

John J. Tatum

White

x

apt. 17, 1955 94

Balto. Md. USA

Chamney E. Tatum, 6105 Edmonson Ave

Burial 3/30/61

London Ark

Baltimore 28, 1961

Wesley E. 6101 Edmonson Ave

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

1

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upperco (Rural)				c. LENGTH OF STAY IN 1b 50 yrs.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES REVERDY TAWNEY				4. DATE OF DEATH Month Mar. Day 13 Year 19 61							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 25, 1888		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Tawney				14. MOTHER'S MAIDEN NAME Agnes Taylor							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no				16. SOCIAL SECURITY NO. 218-32-5118		17. INFORMANT Address Charles T. Tawney, Upperco, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none										INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m.				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		2Df. (City or town) none		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 3-14-61			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				6 Hanover Rd., Reisterstown, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-61		22c. NAME OF CEMETERY OR CREMATORY Trenton				22d. LOCATION (City, town, or country) (State) Balto. Co. Md.			
23. FUNERAL DIRECTOR ADDRESS Edward C. Tipton, Hampstead, Md.						24a. REC'D BY REGISTRAR DATE MAR 20 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

M

0328

1001:16

CERTIFICATE OF DEATH

Reg. Dist. No.

02843

2861

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Middle River</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>605 Wampler Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Daisy Davis-Taylor</u>		4. DATE OF DEATH <u>March 16</u> 19 <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 16, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Rost</u>		14. MOTHER'S MAIDEN NAME <u>Kate Rule</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph L. Davis</u>		Address <u>605 Wampler Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>General arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 11</u> , 19 <u>49</u> , to <u>March 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>61</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irving R. Beck</u>		DATE SIGNED <u>March 16, 1961</u>	
PHYSICIAN'S NAME (Type) <u>IRVING R. BECK</u>		ADDRESS (Street, city or town, state) <u>901 Furlong Ave Baltimore 20 Md @ 1197</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-20-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OREN'S Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Middle River Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip E. C. Vach</u>		ADDRESS <u>1211 Chesa Ave.</u>	
24a. REC'D BY REGISTRAR <u>MAR 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

108850

CERTIFICATE OF DEATH

1881

(M)

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and lines for information.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2862

CERTIFICATE OF DEATH

Reg. Dist. No.

02844

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b one yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 Kinship Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle FRANKLIN Last TIMMONS, Sr.				4. DATE OF DEATH Month March Day 2nd Year 19 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 30, 1894	9. AGE (In years last birthday) 66 yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Wh. Meat		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Timmons				14. MOTHER'S MAIDEN NAME Sarah Carr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 215-09-9489		17. INFORMANT Sarah L. Timmons		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis (acute) DUE TO (c) 10 min 5 yr 1 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1, 1961 to MAY 2, 1961 , that I last saw the deceased olive on MAY 1, 1961 , and that death occurred on 3:00A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 33 Dundalk Avenue DATE SIGNED 3/3/61 ACTUAL SIGNATURE David H. Andrew M.D. PHYSICIAN'S NAME (Type) David H. Andrew, M.D. Baltimore 22, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/61		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md				24a. REC'D BY REGISTRAR DATE MAR 6 '61		24b. REGISTRAR'S SIGNATURE Arthur L. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1962

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-26		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Author		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 170	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PLACE OF DEATH Memphis, Tenn.		14. DATE OF DEATH 4-4-68		15. TIME OF DEATH 10:15 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		18. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		19. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		20. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
21. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		22. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		23. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		24. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		25. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
26. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		27. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		28. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		29. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		30. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
31. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		32. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		33. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		34. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		35. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
36. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		37. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		38. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		39. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		40. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
41. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		42. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		43. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		44. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		45. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
46. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		47. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		48. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		49. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		50. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
51. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		52. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		53. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		54. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		55. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
56. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		57. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		58. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		59. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		60. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
61. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		62. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		63. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		64. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		65. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
66. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		67. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		68. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		69. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		70. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
71. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		72. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		73. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		74. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		75. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
76. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		77. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		78. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		79. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		80. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
81. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		82. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		83. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		84. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		85. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
86. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		87. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		88. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		89. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		90. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
91. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		92. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		93. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		94. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		95. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	
96. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		97. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		98. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		99. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover		100. SIGNATURE OF DEATH CERTIFICATE J. Edgar Hoover	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

3
2863
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02845

Items 23c & d, fill in 23d 4/10/61 iwk

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Pr. Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 5 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights 1627-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 420 57 th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EVERETT		Middle WILLIAM		Last TOMLINSON		4. DATE OF DEATH Month 3 Day 28 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8.21.1908	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BERNARD TOMLINSON				14. MOTHER'S MAIDEN NAME VIRGINIA SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis						INTERVAL BETWEEN ONSET AND DEATH 15 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-11-1960 to 3-28-1961, that (I) (we) last saw the deceased alive on 3-28-1961, and that death occurred at 7:05 AM from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3.31.1961	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial April 4, 1961		23b. DATE THEREOF April 4, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell				ADDRESS 1001 E. Pratt St. Baltimore, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Traub	

MEDICAL CERTIFICATION

3883

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
OFFICE OF VITAL RECORDS
STATE OF NEW YORK

1988



CERTIFICATE OF DEATH

Reg. Dist. No.

02846

2864

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 71 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 334 Oella Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle William Last Treuth				4. DATE OF DEATH Month March Day 3 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1889	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 71 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Packing				10b. KIND OF BUSINESS OR INDUSTRY Owner of Business		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Charles William Treuth			
14. MOTHER'S MAIDEN NAME Mary A. Keiner				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 217-01-4006				17. INFORMANT Mr. John W. Treuth Jr. 334 Oella Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus							
INTERVAL BETWEEN ONSET AND DEATH 2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 10, 1958 to March 3, 1961 , that I last saw the deceased alive on February 28, 1961 , and that death occurred at 8 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. Cassaway M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED 3/3/61			
PHYSICIAN'S NAME (Type) Dr. William F. Cassaway				22. LOCATION (City, town, or county) (State) Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment				22b. DATE THEREOF 3/6/61			
22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum				22d. LOCATION (City, town, or county) (State) Woodlawn, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home ADDRESS Catonsville, Md.				24a. REC'D BY REGISTRAR MAR 8 '61 DATE			
24b. REGISTRAR'S SIGNATURE Arthur S. Travis							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

05850

CENTRAL BANK OF GERMANY

1883



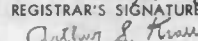
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2865

02847

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 106 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY 3101-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (408 Pitman Place) Baltimore 2, Maryland d. STREET ADDRESS 408 Pitman Place (2) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE Z. TURNER First Middle Last		4. DATE OF DEATH March 14 1961 Month Day Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/94
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barbering	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Robinson		14. MOTHER'S MAIDEN NAME Liddy MN: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO. 217-32-9462	
17. INFORMANT CLin. Rec., VAH, Baltimore 18, Md., Ft. Howard Div.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO 1810 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) PYELONEPHRITIS AND PYONEPHROSIS (c) CARCINOMA, BLADDER WITH METASTASIS TO MESENTERIC & ILIAC LYMPH NODES (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operations: 1. Pyelostomy, left for ureteral obstruction. Laparotomy 3/10/61			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from November 23, 1960 to March 14, 1961 , that (X) (we) last saw the deceased alive on March 14, 1961 , and that death occurred at 6:40 M, from the causes and on the date stated above.			
22a. SIGNATURE  M.D.		22b. DATE SIGNED 3/14/61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.		22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD, DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-17-61	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis Mortuary, 1639 N. Broadway, Balto.		25e. REC'D BY REGISTRAR MAR 15 '61	25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

13, Md.

9884

3883

M

1

[Handwritten signature]

OFFICE OF THE ATTORNEY GENERAL

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MAY 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
2866
Items 23a, b, c & d Film G283 3/20/61 iwk
02848

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 35yr25days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 729 Montford Avenue (S) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Julia Schuland Tyma			4. DATE OF DEATH Month March Day 5 Year 1961		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 12, 1882		9. AGE (In years last birthday) 78 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY tailor shop		11. BIRTHPLACE (County & State, or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Poland			13. FATHER'S NAME Matthew Tyma		
14. MOTHER'S MAIDEN NAME Mary Salboszeka			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) unknown		
16. SOCIAL SECURITY NO. unknown			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 weeks long standing					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1955 , to March 5, 1961 that (I) (we) last saw the deceased alive on March 5, 1961 , and that death occurred at 8:45 p.m. from the causes and on the date stated above.					
22a. SIGNATURE Stella Wachslar M.D.			22b. DATE SIGNED 3-5-61		
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.			22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/11/61		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus	
23d. LOCATION (City, town or county) Baltimore		(State) Md.		25a. REC'D BY REGISTRAR DATE MAR 13 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Kaczynski Fun. Serv. 1515 Hub St, Baltimore		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

4880

1880

I

Manuscript in the hands of the
author

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02849

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b 1216 LANDINGTON AVE.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1216 LANDINGTON AVE.		d. STREET ADDRESS 1216 LANDINGTON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Stanley		First Stanley		Middle UDES	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH OCT. 9, 1911		9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME CHARLES UDES		14. MOTHER'S MAIDEN NAME MARY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W. W. II		17. INFORMANT Mrs. Catherine M. Udes - 1216 Landington Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning. 973.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Inhalation of carbon monoxide		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inhalation of carbon monoxide		20c. TIME OF INJURY Month, Day, Year 6:45 p.m. 3/18 1961	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) car		20f. (City or town) (County) (State) Baltimore Baltimore Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 18, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-22-61		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	
22d. LOCATION (City, town, or country) (State) Balto. Md.		23. FUNERAL DIRECTOR Julius Cronan, 674 E. - Catonsville, Md.		24a. REC'D BY REGISTRAR MAR 24 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. House					

05219

NO

1210 S. 1st Ave.

101 18

101 18

101 18

101 18

1

San Francisco, California

March 10, 1901

Wm. V. L. L. L.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

M
I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02850

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 523 Goucher Blvd			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 523 Goucher Boulevard e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) John L. WALTERS, Jr.			4. DATE OF DEATH Month Day Year March 23, 19 61		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5-11-1910		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CROWN - CORK & Seal Co		10b. KIND OF BUSINESS OR INDUSTRY TOWSON, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. WALTERS, Sr		14. MOTHER'S MAIDEN NAME Alice M. MAISEL		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Alice M. BAKER		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction of interventricular septum. 420.1 Conditions, if any, which gave rise to immediate cause (b) DOOR (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William N. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 24, 1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-28-61		22b. DATE THEREOF MORCLAND PK		22c. NAME OF CEMETERY OR CREMATORY BALTO Md	
23. FUNERAL DIRECTOR Lernard J Ruck		ADDRESS 5305 Hayford		24a. REC'D BY REGISTRAR MAR 27 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					



009

 $\frac{1}{2}$ 

Myanmar's Independence 20 years after the 1948

• 1947年8月

22

• • • • •

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2869 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02851										
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland- b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 523 Goucher Boulevard					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 523 Goucher Blvd.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MILDRED B. WALTERS					4. DATE OF DEATH Month March Day 23 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 26, 1918		9. AGE (In years last birthday) 42		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Secretary		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Charles Edward BEVANS					14. MOTHER'S MAIDEN NAME M. ELEANOR HANDERS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					
					17. INFORMANT Florence C. Stinchcomb Address 1718 E 29th ST.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis. 420.1 XXXX Coronary Insufficiency. Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE William V. Lovitt, Jr., M.D.					DATE SIGNED March 24, 1961					
EXAMINER'S NAME (Type)					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 3/28/61		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem.		22d. LOCATION (City, town, or country) (State) BALTIMORE, Md.	
23. FUNERAL DIRECTOR L. J. Ruck					24a. REC'D BY REGISTRAR 5305 HARFORD Rd.		24b. REGISTRAR'S SIGNATURE DATE MAR 27 '61			

M

• • • • •

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2870

CERTIFICATE OF DEATH

Reg. Dist. No. 02852

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>		c. LENGTH OF STAY IN 1b <i>80 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Quaker Bottom Rd #1</i>		d. STREET ADDRESS <i>Quaker Bottom Rd #1</i>	
3. NAME OF DECEASED (Type or print) <i>Joseph Watkins</i>		4. DATE OF DEATH <i>March 21 1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>14 February, 1876</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Pretty Boy Town area</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>UNKNOWN</i>	
14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Daughter Ella Dorsey</i> Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio-sclerotic cardio vascular disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i> <i>15 years</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1946 to March 1961</i> , that I last saw the deceased alive on <i>7 March 1961</i> , and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		DATE SIGNED <i>21 March 1961</i>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>3-24-1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>STEVENSON A. M. E.</i>	22d. LOCATION (City, town, or county) (State) <i>SPARKS, MARYLAND</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>WILLIAM A. JACKSON FUNERAL H. INC.</i>		24a. REC'D BY REGISTRAR <i>916 PENNA. AVE.</i>	24b. REGISTRAR'S SIGNATURE <i>William S. King</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED'S NAME		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. J. J.		JAN 1 1900		BALTIMORE, MD	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 1 1900		BALTIMORE, MD		HEART DISEASE	
TIME OF DEATH		MANNER OF DEATH		OCCUPATION	
10:00 AM		NATURAL		LABORER	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
J. J. J.		J. J. J.		J. J. J.	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
J. J. J.		J. J. J.		J. J. J.	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 1 1900		JAN 1 1900		JAN 1 1900	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02853

2871

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) 301 Church Lane		d. STREET ADDRESS 301 Church Lane	
3. NAME OF DECEASED (Type or print) Eliza Maude Watts		4. DATE OF DEATH March 20, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1889
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pikes. 5&10		10b. KIND OF BUSINESS OR INDUSTRY Merchandise	
11. BIRTHPLACE (State or foreign country) Baltio. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Keck Pearce		14. MOTHER'S MAIDEN NAME Annie Eliza Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-22-4454	
17. INFORMANT Mr. M. Pearce Watts		Address Pikesville 8, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure - Chronic DUE TO (c) Arteriosclerosis - generalized		INTERVAL BETWEEN ONSET AND DEATH Minutes 3 1/2 years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1957 to March 20, 1961 , that I last saw the deceased alive on March 17, 1961 , and that death occurred at 12:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence E. McWilliams		DATE SIGNED March 20, 1961	
PHYSICIAN'S NAME (Type) Clarence E. McWilliams		ADDRESS (Street, city or town, state) 11904 Reisterstown Rd., Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 23, 1961	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Pikesville 8, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Howell		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2872

CERTIFICATE OF DEATH

Reg. Dist. No. 02854

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN lb 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Joseph Nur. Home				d. STREET ADDRESS 34 Oakleigh Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Daisy A. Weber				4. DATE OF DEATH March 10 61			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1882	
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Cashier (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Hoch. Kohn		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Otto Weber				14. MOTHER'S MAIDEN NAME Sarah Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
INFORMANT Brother				Address 1625 E. 32nd St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 199X DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterioscl. cardiovascular disease							
INTERVAL BETWEEN ONSET AND DEATH 3 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January , 19 61 to March 10 , 19 61 , that I last saw the deceased alive on March 10 , 19 61 , and that death occurred at 1:30 P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Justinas Kudirka M.D.				ADDRESS (Street, city or town, state) 1709 Edmonson ave, Baltimore Md.			
PHYSICIAN'S NAME (Type) Justinas KUDIRKA				DATE SIGNED 3.12.61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/ 61		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P. A. Heemann				ADDRESS 6067 Harford Rd.			
24a. REC'D BY REGISTRAR MAR 16 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02854

CLERK OF DEATH

1873

Id.

Baltimore

Baltimore

Catholics

54 Oakleigh Rd.

St. Joseph's Home

Person 10 61

73

Dec. 24

Baltimore

Catholic (Rite) John

Barth Lewis

Otto Weber

1623 E. 32nd St.

Brother

Baltimore Md.

St. Oliver Cem.

Born 1871

P. A. Hermann 6067 Hartford Rd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
2873											
02855											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2532 Windsor Road</u>						d. STREET ADDRESS <u>2532 Windsor Road</u>					
3. NAME OF DECEASED (Type or print) <u>Basil Smith Wellener, Jr.</u>						4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1961</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-7-1880</u>		9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Assemblyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bendix Corp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME <u>Basil S. Wellener, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Kate W. Hamill</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u>215070654A</u>						17. INFORMANT <u>Elenora Wellener</u> Address <u>same</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Arteriosclerotic Cardio Vascular Disease with Hypertension</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 years</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>24-June-1953</u> to <u>26-March-1961</u> that (I) (we) last saw the deceased alive on <u>25-March-1961</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Chas W Edmonds</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>27-March-1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Chas W Edmonds</u>						22d. ADDRESS <u>2746 The Alameda</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>3-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>						25a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

02833

02833

(M)

(I)



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2874

CERTIFICATE OF DEATH

02856

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Conv. Home</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>237 Rollingbrook Way</u>			
3. NAME OF DECEASED (Type or print) <u>Mollie P. Welsh</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11, 1875</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hom.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>John Stevens</u>				
14. MOTHER'S MAIDEN NAME <u>Brass</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>				
16. SOCIAL SECURITY NO. <u> </u>			17. INFORMANT <u>Mr. Spencer Welsh</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Discompensation</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>2 mts.</u> <u>15 yrs.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-31-1961</u>, to <u>3-10-1961</u>, that (I) (we) last saw the deceased alive on <u>3-10-1961</u>, and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilmer K. Gallagher</u>		22b. DATE SIGNED <u>3-13-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, M.D.</u>			
22d. ADDRESS <u>6209 Frederick Ave, Balt. 28, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
23b. DATE THEREOF <u>3/13/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Pratt & Son</u>			25a. REC'D BY REGISTRAR <u>28</u>				
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			DATE <u>MAR 14 '61</u>				

TO HOSE L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or nursing home, the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05250
OFFICE OF THE
1722



[Faint, mostly illegible handwritten text, possibly a letter or document.]

[Faint, mostly illegible handwritten text at the bottom of the page.]

WESTERNMAN

CERTIFICATE OF DEATH

3201 Tyndale
Reg. Dist. No. Balto City

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>9 1/2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6811 Campfield Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>BARBARA</u> Last <u>WESTERMAN</u>		4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 18, 1870</u>
9. AGE (In years last birthday) <u>91 yrs.</u>		10. UNDER 1 YEAR Months <u>91</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frederick KOWALLER</u>		14. MOTHER'S MAIDEN NAME <u>Luella Reisinger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5th Katenkampfs 6811 Campfield</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) - Broncho-Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>(2) Arterio-Sclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arterio Sclerotic Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerotic Heart</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>0</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>March 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 7-1961</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4108 Liberty Hts. Ave. Balto. Md. 3-8-61</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers - M.D.</u>		<u>4108 Liberty Hts. Balto-Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-11-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Saint Paul's Lutheran Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>David Hill Park. Coll. Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Miller & Co. - 2431 E. Olney St.</u>		ADDRESS <u>2431 E. Olney St.</u>	
24a. REC'D BY REGISTRAR <u>MAR 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION

1

1



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2876

CERTIFICATE OF DEATH

Reg. Dist. No. 02858

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b X Dickeyville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home				d. STREET ADDRESS 15002 Wetheredsville Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORENCE		First A.		Middle WETTSTEIN		Last March 6 19 61	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1885	
9. AGE (In years lost birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Delmont Angel				14. MOTHER'S MAIDEN NAME Atta Roat			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 391-24-7894			
INFORMANT Mrs. Ruth W. Carter-5608 Dogwood Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast c metastases DUE TO (c) 25 years				INTERVAL BETWEEN ONSET AND DEATH 11 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/20 , 19 57 to 3/6 , 19 61 that I last saw the deceased alive on 3/2 , 19 61 , and that death occurred at 2 1/2 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 3408 Windsor Ave. 3/7/61			
ACTUAL SIGNATURE Robert A. Reiter				DATE SIGNED 3/7/61			
PHYSICIAN'S NAME (Type) ROBERT A. REITER, M.D.				Garrison Blvd. & Windsor Ave.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/1961		22c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost-4600 Liberty Hghts. Ave.				24a. REC'D BY REGISTRAR DATE MAR 9 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BRANDS ATTACHED - 4000 Liberty High Ave.

Serial: 1000001

Liberty Machine Works

Woolly

THOMAS ROBERT, RAYNER, W.D. - Carlson Blvd. E. Winona Ave.

Yours truly,
W.D. Rayner

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

W.D. Rayner
12/20/20

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02859

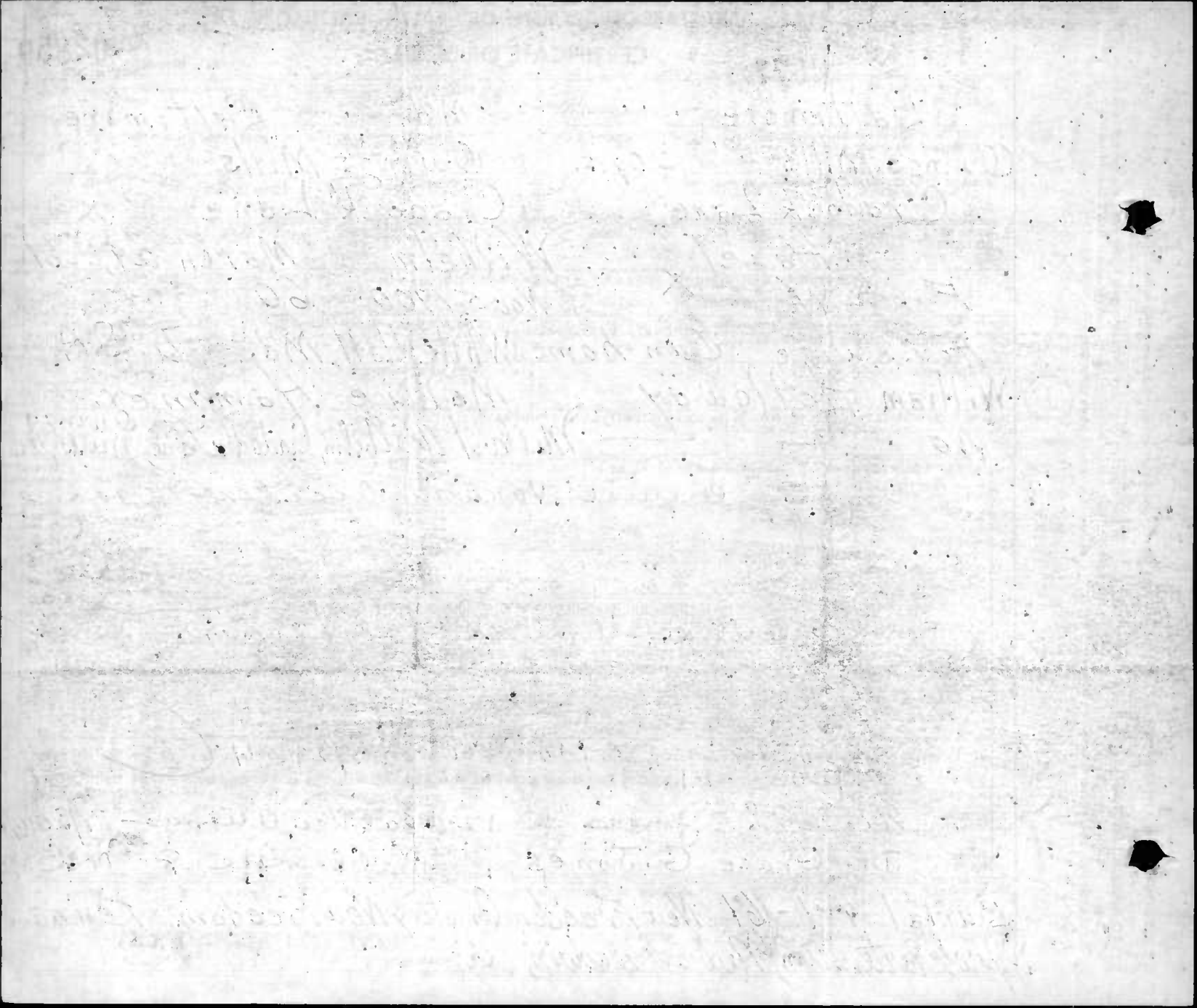
2877

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Owings Mills.</u>	
c. LENGTH OF STAY IN 1b <u>20yrs.</u>		d. STREET ADDRESS <u>1 Cradock Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cradock Lane</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hazel</u> Middle <u>Wilhelm</u> Last <u>Wilhelm</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 5, 1900</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home, White Hall, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Holloway</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Hammer.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Former cerebral thrombosis + paralysis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/19</u> , 19 <u>61</u> , to <u>3/29</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>61</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Grace G. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>12 Walker Avenue Baltimore 8 - Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Grace G. Jones</u>		DATE SIGNED <u>3/30/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-1-61</u>	<u>New Freedom Cemetery</u>	<u>New Freedom, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Kortenski</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>APR 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

(M)

(I)

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02860

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. LENGTH OF STAY IN 1b <u>25yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old York Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Virginia C. Wineholt</u>		4. DATE OF DEATH <u>March 2, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1904</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing Factory Petersburg, W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Cameron Cochran</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hutton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>168-14392</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>Arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2, 1961</u> to <u>Mar 2, 1961</u> , that I last saw the deceased alive on <u>Mar 2, 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. France</u> M.D.		DATE SIGNED <u>3/4/61</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 5, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>New Freedom Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR <u>MAR 7 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>John S. Hume</u>	

CERTIFICATE OF DEATH

00220

1

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02861

2879

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
c. LENGTH OF STAY IN 1b <i>1 yr.</i>				d. STREET ADDRESS <i>6215 Norvo Rd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6215 Norvo Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Louis</i> Middle <i>Wolf</i> Last <i>Wolfe</i>				4. DATE OF DEATH Month <i>Mar.</i> Day <i>18</i> Year <i>1961</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 18, 1891</i>	
9. AGE (In years last birthday) <i>69</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sailor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shop</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Jacob Wolfe</i>		14. MOTHER'S MAIDEN NAME <i>Saga ?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>(blank)</i>		17. INFORMANT <i>Blanche Wolfe</i> Address <i>Same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung with metastases to kidney</i> DUE TO (b) <i>(blank)</i> DUE TO (c) <i>(blank)</i>							INTERVAL BETWEEN ONSET AND DEATH <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/1/61</i> 19 <i>61</i> , to <i>3/10/61</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>3/10/61</i> 19 <i>61</i> , and that death occurred at <i>10 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Milton Schleroff</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Milton Schleroff</i>				22d. ADDRESS <i>6410 Windsor Mill Rd.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>3/19/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Karneth Israel</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Sal Levinson & Bros. Inc.</i>				25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
ADDRESS <i>6010 Reisterstown Rd.</i>				DATE <i>MAR 21 '61</i>			

MEDICAL CERTIFICATION



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to be a medical or legal record.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2880

CERTIFICATE OF DEATH

Reg. Dist. No. 02862

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN TB 3 Mo.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 1924 Haselmere Road				d. STREET ADDRESS 1 1924 Haselmere Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLORA Middle WOODARD Last WOODARD		4. DATE OF DEATH Month March Day 24 Year 19 61					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1900	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 61 Days 19 Hours 61 Min.	IF UNDER 24 HRS. Months 19 Days 61 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dodson			14. MOTHER'S MAIDEN NAME Alice Leake				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. Julia Brady 1924 Haselmere Rd. 22			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 155.1 DUE TO CA. of Gall Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Unknown (b) CA. of Gall Bladder DUE TO Unknown (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Dundalk		20g. (County) Md.		20h. (State) Md.			
21. I certify that I attended the deceased from 20 Feb 1961 , to 24 Mar 1961 , that I last saw the deceased alive on 23 Mar 1961 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W.H. Morrison M.D.			ADDRESS (Street, city or town, state) 3 Kiship Rd Dundalk 22 Md.				
PHYSICIAN'S NAME (Type) W.H. Morrison			DATE SIGNED 23 Mar 61				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-27-1961		22c. NAME OF CEMETERY OR CREMATORY Loudon Park			
22d. LOCATION (City, town, or county) Frederick Rd. Md.		22e. (State) Md.		22f. (Country) U.S.A.			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave, 22, Md.			24a. REC'D BY REGISTRAR DATE MAR 28 '61				
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			24c. (City or town) Dundalk				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02863

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowley's Quarters		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowley's Quarters	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clarks Point Rd.		d. STREET ADDRESS Clarks Point Rd.	
3. NAME OF DECEASED (Type or print) Maude First Edwina Middle York Last		4. DATE OF DEATH March 29 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1884
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown McElroy		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-22-8443	
17. INFORMANT Mrs. Milton R. Stewart		Address Box 79 Rt. 15 (20)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-vascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1961, to March 29, 1961, that I last saw the deceased alive on March 29, 1961, and that death occurred at 2:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G.M. Baumgardner M.D.		ADDRESS (Street, city or town, state) Balto 6 Md	
PHYSICIAN'S NAME (Type)		DATE SIGNED 3/29/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-1961	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer		22d. LOCATION (City, town, or county) (State) Chase, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2882

02864

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonersville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonersville</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>2 1/2 Dutton Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2 1/2 Dutton Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jan F. Young</u>				4. DATE OF DEATH Month Day Year <u>3 11 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>51</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor mng. Motor Transport</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wet India</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Neil F. Young</u>				14. MOTHER'S MAIDEN NAME <u>Mackay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>1081-09-8954</u>			
17. INFORMANT <u>Wm. E. Howard</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Coronary artery disease</u> (c) <u>Arterial hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> , 19 <u>57</u> to <u>March 11</u> , 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>March 11</u> , 19 <u>61</u> , and that death occurred at <u>11:57 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Nesbitt Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>				22d. ADDRESS <u>1118 St Paul St., Baltimore 2, Ind.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3/14/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Howard</u>				ADDRESS <u>28</u>		25a. REC'D BY REGISTRAR <u>MAR 14 61</u> DATE	
				25b. REGISTRAR'S SIGNATURE <u>William E. Howard</u>			

VR A15 (4)
15M 9/60

03803

3282

11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

2883

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02865

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Putty Hill				c. LENGTH OF STAY IN 1b X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7922 Rolling View Road				d. STREET ADDRESS 7922 Rolling View Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JUSTINE Middle ZOLMAN Last				4. DATE OF DEATH Month March Day 22 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 23, 1883	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Wunder				14. MOTHER'S MAIDEN NAME Catherine Ziprick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.				16. SOCIAL SECURITY NO. No.		17. INFORMANT Mrs. John Raschka 1409 Vesper Ave.-22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis acute 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis, chronic DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 1 mos. 1 yr. 2 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Jan 1945 to Mar 22, 1961 , that (I) (we) last saw the deceased alive on Mar 21, 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above.							
22a. SIGNATURE David H. Andrew				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/23/61	
22c. PHYSICIAN'S NAME (Type) David H. Andrew				22d. ADDRESS 33 Dundalk Ave Dundalk Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Christ Lutheran Cemetery		23d. LOCATION (City, town, or county) (State) Dundalk, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.,				25a. REC'D BY REGISTRAR MAR 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

10863

CERTIFICATE OF DEATH

2383

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

W

1908

W

1908

1908

1908

1908

1908

1908

1908

1908

1908